C.L. "BUTCH" OTTER – Governor RICHARD M, ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

January 2, 2008

Sandra Bruce St Alphonsus Regional Medical Center 1055 North Curtis Road Boise, Idaho 83706

RE: St Alphonsus Regional Medical Center, provider #130007

Dear Ms. Bruce:

This is to advise you of the findings of the Medicare survey at St Alphonsus Regional Medical Center which was concluded on November 20, 2007.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. <u>It is important</u> that your Plan of Correction address each deficiency in the following manner:

- 1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for <u>all</u> individuals potentially impacted by the deficient practice.
- 2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
- 3. Identify the date each deficiency has been, or will be, corrected.
- 4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by <u>January 15, 2008</u>, and keep a copy for your records.

Sandra Bruce January 2, 2008 Page 2 of 2

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

**GARY GUILES** 

Health Facility Surveyor

Non-Long Term Care

SYĽVIA CRESWELL

Co-Supervisor

Non-Long Term Care

GG/mlw

Enclosures

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COO OFFICE

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December 27, 2007

Sylvia Creswell Idaho Department of Health and Welfare 3232 Elder Street P.O. Box 83720 Boise, Idaho 83720-0036

Dear Ms. Creswell:

Attached please find Saint Alphonsus Regional Medical Center's plan of correction which is intended to address and rectify deficiencies cited during a Medicare/Licensure survey conducted on November 20, 2007. The documents included are:

- 1. Saint Alphonsus' plan of correction
- 2. Appendices A-M to the plan of correction
  - a. Revised Restraint and Seclusion policy
  - b. Restraint and Seclusion educational materials
  - c. Letter to physician regarding prn restraint orders
  - d. Letter to physician regarding signing restraint orders daily
  - e. NDNQI Guidelines for data collection for pressure ulcers
  - f. Pressure ulcer prevalence study results
  - g. Pressure ulcer prevalence results for Saint Alphonsus compared to Trinity Health System
  - h. Pressure Ulcer Performance Improvement Plan
  - i. Revised Braden Scale for predicting Pressure Ulcer Risk and Skin Assessment policy
  - Revised Wound and Pressure Assessment and Care; Culture, Irrigation and Debridement policy
  - k. Revised Nursing Admission Assessment form
  - 1. Pressure Ulcer education materials
  - m. Skin Assessment audit form
  - n. Restraint Audit form

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. The hospital takes the issues raised during the survey very seriously and have worked diligently to address each one.

We appreciate your thoughtful consideration of this plan of correction. We look forward to your acceptance of our plan and the revisit to verify our compliance.

Please contact Aline Lee, RN, Director of Patient Safety and Regulatory Compliance at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Sanges & Bruco

Sandra B. Bruce

President and CEO

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		TIPLE CONSTRUCTION .	(X3) DATE SU	
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		130007	B. WIN	1G _		11/20	0/2007
	ROVIDER OR SUPPLIER	MEDICAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
A 000	INITIAL COMMENT	rs	Α (	000			
A 164	recertification and of your hospital. Suinvestigation were:  Gary Guiles, RN, H Patrick Hendrickson Rae Jean McPhillip Patricia O'Hara, RN  Acronyms used in to CHF = Congestive CWOCN = Certified Nurse DNS= Director of NED = Emergency DEMR = Electronic NEMTEK = Hospital's System ET = Certified Wou consult ICU = Intensive Call Nsg = Nursing PI = Program Impropension PRN = As Needed PT = Physical Therese Pt = Patient RN = Registered Not SARMC = ST Alpho Center TIA = Transient ischure TIA = Transient ischure TIA = Transient ischure TIA = Transient ischure Times	n, RN, HFS s, RN, HFS l, HFS he survey report include: Heat Failure d Wound-Ostomy-Continence fursing lepartment Medical Record is Electronic Documentation ind-Ostomy-Continence Nurse re Unit lovement lapist urse lonsus Regional Medical memic attack	Α 1	164	Please see following down	7 2007 ANDARDS	
A 164	OR SECLUSION	on may only be used when	A 1	164			
	less restrictive inter						
ABORATOR	DIRECTOR'S OR PROVIDE	DER/SUPPLIER REPRESENTATIVE'S SIGN			12/21/67		(X6) DATE

ciency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## Plan of Correction Response to Findings of November, 2007 Survey Saint Alphonsus Regional Medical Center

Tag	Issue	Action	Responsible Person	Completion Date
A 000	INITIAL COMMENTS			
	The College de College			CLAPP .
	The following deficiencies were cited during the recertification and			
	complaint investigation survey of your hospital. Surveyors conducting the investigation were:			
	conducting the investigation were.			
	Gary Guiles, RN, HFS, Team Leader			
	Patrick Hendrickson, RN, HFS			
	Rae Jean McPhillips, RN, HFS			
	Patricia O'Hara, RN, HFS			
	Acronyms used in the survey report include:			
	CHF = Congestive Heart Failure			
	CWOCN = Certified Wound-Ostomy-Continence Nurse			
	DNS = Director of Nursing			
	ED = Emergency Department			
	EMR = Electronic Medical Record			
	EMTEK = Hospital's Electronic Documentation System			
	ET = Certified Wound-Ostomy-Continence Nurse consult			- Andrews
	ICU = Intensive Care Unit			
	Nsg= Nursing			
	PI = Performance Improvement			
	PRN = As Needed			
	PT = Physical Therapist			
	Pt = Patient			
	RN = Registered Nurse			
	SARMC = ST Alphonsus Regional Medical Center			
	TIA = Transient Ischemic attack			
A 164	UE = Upper extremity			
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR			
	SECLUSION			

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient and others from harm. The STANDARD is not met as evidenced by: based on review of clinical records and staff interview, it was determined the hospital failed to ensure restraints would only be used when less restrictive interventions had been determined to be ineffective to protect the patient from harm. This was the case for 3 of 4 sampled patients (#s 42, 43, and 44), who had been placed in restraints, to protect from harm. The findings include: The "Restraint and Seclusion" 1. The policy "Restraints and Seclusion" not dated stated "Ill. Aline Lee. 12/12/07 Initiation of Restraint/Seclusion: B...a regist4ered nurse may policy has been revised to Director of initiate restraint/seclusion based on an appropriate assessment of include a description of the **Patient Safety** the patient". The items to be assessed, including the use of less items to be assessed before and restrictive measures, were not specified in the policy. The Director initiating restraints. Please Regulatory Compliance of Patient Safety, interviewed on 11/20/07 at 10:00 AM, stated see Appendix A, Restraint and Seclusion policy, section II. B. specific assessments to ensure consistency for all nurses, had not The policy requires been developed. documentation of the less 2. The hospital failed to ensure less restrictive interventions had restrictive measures been determined to be ineffective prior to the use of restraints, for considered or attempted prior to applying or continuing 3 of 4 sampled patients (#'s 42, 43, and 44) who had been placed in restraints. Examples include: restraints. Please see Appendix A, section IV. B. \*Patient #42 was a 90 year old female who was admitted to the Please note that policies hospital on 10/19/07 with diagnosis of urinary tract infection and include the original, review, Alzheimer's disease. She was discharged on 10/22/07. An order and revision dates at the end on 10/19/07 at 2:00 PM stated that the patient was unsafe to be of the policy. out of bed and was attempting to get out of bed. A vest restraint Train-thewas ordered. The restraint was re-ordered on 10/20, 10/21, and Education for staff regarding Aline Lee, 10/22/07. From 2:00 PM on 10/19/07, the patient remained use of restraints and seclusion Director of trainer restrained during her entire stay at the hospital. No nursing note was accomplished through a **Patient Safety** sessions was documented specifically describing the patient's behavior that train-the-trainer approach. and wete Trainers were identified for Regulatory conducted indicated the need for restraints or what specific less restrictive Compliance on 12/12/07, measures had been tried prior to the use of restraints. Nursing each unit. The unit trainers

attended one of three sessions

conducted by the clinical

notes at 8:00 PM on 10/19/07 stated the patient was restless and

trying to get out of bed. At 4:00 AM on 10/20/07 the patient was

12/14/07,

and

noted to be sleeping in a chair. The patient was confused but no restlessness or behavioral problems were documented through 3:13 PM on 10/22/07 when she was discharged.

Nurses chose letters from a computerized list to indicate which less restrictive measures had been utilized. When the restraint was initiated on 10/19/07 at 2:00 PM, the nurse chose "Alarm" from a computerized list which documented "A" on the patient's medical record. Other letters were documented at times throughout the patient's stay which meant "Medication, Reality Orientation, Diversionary Activity, Education/Limit Stetting, and Modification of Environment. The letters did not describe what the less restrictive measure meant or what the patient's response was to the intervention. For example, Modification of Environment (E) was documentation 4 times in the patient's record. It was not documented what kind of modification tot he patient's environment had been made or what the patient's response was. "Education/Limit setting" was documented 3 times. It was not documented what this meant or whether it was effective. The 6 West Charge Nurse, where the patient resided during her stay, was interviewed at 11:00 AM on 11/8/07. She reviewed the record and stated a specific assessment of the need fro restraints, including the use of less restrictive measures and their effectiveness, was not documented in the record.

\*Patient #44 was an 86 year old male who was admitted to the hospital on 9/30/07 with a diagnosis of a left-sided subdural hematoma. He was discharged from the hospital on 10/8/07. A verbal order for wrist and chest restraints, obtained on 10/2/07 at 11:30 AM, documented the patient was attempting to get out of bed and had cognitive impairment. On 10/4/07 (untimed) an order for vest, wrist and ankle restraints documented the patient continued to attempt to get out of bed and was cognitively impaired. Additionally, contained in the record was an undated and untimed order for v3est, wrist and ankle restraints with no documented reason for restraints. There was no documentation in the record for 10/2/07 that indicated the reason for the implementation of wrist restraints. On 10/3/07 at 4:00 AM, it was documented that ankle restraints were used in addition to the vest

educators. At these sessions, the trainers received packets containing flyers, revised policies, a summary of the changes to the electronic medical record (EMR) or paper forms, and talking points for use at staff meetings, in-services, posters, bulletin boards, or other forms of communication. In addition to the trainers, other staff were available to round on units to provide one-to-one coaching and evaluation of testraint use and documentation. Education focused on the following key points:

- 1. Ongoing assessment of the need for restraint and removal of restraints when less restrictive measures are effective.
- 2. Documentation that describes the patient's behavior and condition that necessitates the use of restraint.
- 3. Specific documentation of the less restrictive measures attempted or considered using the pick lists as well as narrative entries if necessary to describe the specific interventions.

12/1//07. Unit education completed by 12/27/07. and wrist restraints. Nursing notes, dated 10/3/07 at 6:50 AM, documented the patient was "increasingly agitated, calmed with PRN pain meds and Haldol..." There was no documentation in the record for 10/3/07 that indicated the reason for the implementation of ankle restraints. On 10/3/07 at 4:00 PM, nursing notes documented the vest restraint was removed but that the wrist and ankle restraints were continued. There was no documentation in the record that indicated the condition of the patient had changed to warrant the removal of the vest restraints or continued use of the wrist and ankle restraints. On 10/4/07 at 8:00 AM, nursing notes documented the wrist and ankle restraints were removed and that the vest restraint was reapplied. The vest restraint was discontinued on 10/7/07 at 8:00 AM. On 11/8/07 at 11:45 AM, the 6 West Charge Nurse and the Director of Patient Safety reviewed the record. They confirmed a specific assessment of the use of less restrictive measures was not documented by nurses who implemented and maintained the restraints.

\*Patient #43 was a 72 year old male with a diagnosis of Stage III multiple myeloma. He was hospitalized for malnutrition and uncontrolled pain on 10/18/07 and expired on 10/27/07. On 10/23/07 he required intubation and was transferred to the ICU. On 10/24/07 at 2:00 AM bilateral wrist restraints were initiated for reasons, checked from a computer list, of Unsafe OOB (unsafe out of bed), ImpCogntn (impaired cognition) and RemovLne (removing a line). These remained in place through 10/25/07 at 9:00 PM and continued through 10/26/07 at 8:00 PM.

There was no documentation in the EMR, during the time periods that the restraints were in place, which indicated less restrictive interventions had been attempted and were ineffective. Additionally, there was no documentation in the EMR during these time periods, that the patient had attempted to get out of bed or attempted to remove a line. Nursing documentation for the same dates that restraints were in place included the following: 10/24 8:00 AM "no movement noted in any extremities. Pt is chemically sedated." 10/24 12:00 PM "Physical reassessment of all parameters...completed, and there are no changes from the previous documentation." 10/24 4:00 PM "Physical reassessment

- 4. Documentation of the patient's response to the less restrictive measures.
- 5. Documentation of why restraints are discontinued.
- Nurses are not to accept prn orders for restraints. The physician should be called to correct the order.

Please see Appendix B, which is an example of the educational packets given to the trainers.

Restraint documentation is audited daily via reports from the EMR and chart review. Appendix N is a copy of the restraint audit form.

A 169	of all parameterscompleted, and there are not changes from the previous documentation." 10/24 8:00 PM "Musculoskeletal: 0 movement, see neuro aboveNeurosensoryMotor Control/Balance/Gait: 0 movement". 10/25 8:00 PM "does not move extremities to command or spontaneously." 10/26 4:00 AM "Physical reassessment of all parameterscompleted, and there are no changes from the previous documentation." 10/26 8:00 AM "Motor Control/Balance/Gain: no movement noted. Musculoskeletal: no movement noted at this time, pt is chemically sedated." 10/26 12:00 PM "Physical reassessment of all parameters completed, and there are no changes from the previous documentation." 10/26 4:00 PM "Physical reassessment of all parameterscompleted, and there are no changes from the previous documentation." 10/26 7:59 PM "Musculoskeletal: flicker of movement noted in UE's."  There was no documentation that an assessment for the need of restraints, including the use of less restrictive measures and their effectiveness had been completed.  482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION  Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).  This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the hospital failed to ensure that physician's orders for restraints were not written for an as needed basis (PRN) for 1 of the 4 sampled patients (#44) who were restrained during hospitalization. The findings include:  1. The hospital's policy "Restraints and Seclusion", not dated, stated "III. Initiation of Restraint/Seclusion: Dorders for restraints or seclusion may not be written as a standing order on an as needed (PRN) basis.	As mentioned, our Restraint and Seclusion policy clearly prohibits the use of prn restraint orders. See Appendix A, Section II, E, 1. The specific physician who wrote this prn order was sent a letter by the Chief Quality and Safety Officer. Please see Appendix C attached. As mentioned above, education to nursing staff emphasized that prn orders are not acceptable and the nurse should contact the physician to clarify the order.	J. Robert Polk, MD VP, Chief Quality and Safety Officer	12/13/07
	2. A PRN order for restraints was written for 1 of 4 sampled			

	patients (#44) examples include:			
	*Patient #44 was a 86 year old male who was admitted to the hospital on 9/30/07 with a diagnosis of left-sided subdural hematoma. He was discharged on 10/8/07. A physician order, dated 10/2/07, documented "may use soft restraints PRN for safety of patient." Nursing notes documented the use of various restraints on the patient from 10/2/07 through 10/7/07.			
	On 11/08/07 at 11:45 AM, the Director of Patient Safety and 6 West Charge Nurse reviewed the patient's clinical record. They confirmed the record contained a physician's order for PRN restraints. Additionally, they confirmed the patient was in restraints from 10/2/07 through 10/7/07.			
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION	As described above, the education for nursing staff emphasized the need for	Aline Lee, Director of Patient Safety	Train-the- trainer sessions
	Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.	ongoing assessment of the need for restraints and removal when less restrictive	and Regulatory Compliance	conducted on 12/12/07, 12/14/07,
	This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the hospital failed to ensure restraints were discontinued at the earliest possible time for 3 of 4 sampled patients (#'s 42,43, and 44), whose records were reviewed for restraint usage. The findings include:	measures are effective.	r	and 12/17/07. Unit education completed by 12/27/07.
	1. The policy "Restraints and Seclusion", not dated, stated "IV. Assessment and Monitoring: B. Nurses assess for continued need for restraint at least every shift and as needed according to time-limited order expiration." This policy had not been followed. A specific assessment of the need to continue restraints was not defined by the implemented and maintained restraints.			by 12/21/01.
	2. Restraints were not discontinued at the earliest possible time for 3 of 4 sampled patients (#'s 42, 43, and 44). Examples included:			1
	*Patient #42 was a 90 year old female who was admitted to the hospital on 10/19/07 with diagnoses of urinary tract infection and Alzheimer's Disease. She was discharged on 10/22/07. An order			

on 10/19/07 at 2:00 PM stated the patient was unsafe to be out of bed and was attempting to get out of bed. A vest restraint was reordered on 10/21, 10/21, and 10/22/07. From 2:00 PM on 10/19/07, the patient remained restrained during her entire stay at the hospital. Nursing notes, at 8:00 PM on 10/19/07, stated the patient was restless and trying to get out of bed. At 4:00 AM on 10/20/07, the patient was noted to be sleeping in a chair. The patient continued to be sleeping in a chair. The patient continued to sleep and was hard to rouse until 8:00 PM on 10/21 when it was noted she was "Awake and alert. Follows commands." The patient was confused but no restlessness or behavioral problems were documented through 3:13 PM on 10/22/07 when she was discharged. Nursing notes chosen from a computerized list beginning throughout the patient's stay stated "Unsafe OOB" (unsafe out of bed) and "RemovLne" (remove line, referring to pulling at an IV or urinary catheter). The nursing notes did not describe unsafe behavior on the part of the patient. The reference to "RemovLne" was not valid as the patient had a vest restraint which would not prevent her from pulling at tubes or lines. The 6 West Charge Nurse, where the patient resided during her stay, was interviewed at 11:30 AM on 11/8/07. She reviewed the record and stated a specific reassessment of the need for restraints was not documented.

\*Patient #44 was an 86 year old male who was admitted to the hospital on 9/30/07 with a diagnosis of left-sided subdural hematoma. He was discharged from the hospital on 10/8/07. A verbal order for wrist and chest restraints, obtained on 10/2/07 at 11:30 AM, documented the patient was attempting to get out of bed and had cognitive impairment. On 10/4/07 (untimed) an order for vest, writs and ankle restraints documented the patient continued to attempt to get out of bed and was cognitively impaired. Additionally, contained in the record was an undated and untimed order for vest, wrist and ankle restraints with no documented reason for restraints. There was no documentation in the record for 10/2/07 that indicated the reason for the implementation of wrist restraints. On 10/3/07 at 4:00 AM it was documented that ankle restraints were used in addition to the vest and wrist restraints. Nursing notes, dated 10/3/07 at 6:50 AM,

documented the patient was "increasingly agitated, calmed with PRN pain meds and Haldol" There was no documentation in the record for 10/3/07 that indicated the reason for the implementation of ankle restraints. On 10/3/07 at 4:00 PM, nursing notes documented the vest restraint was removed but that the wrist and ankle restraints were continued. There was no documentation I the record that indicated the condition of the patient had changed to warrant the removal of the vest restraint or continued use of the wrist and ankle restraints. On 10/4/07 at 8:00 AM, nursing notes documented the rest and ankle restraints were removed and that the vest restraint was reapplied. The vest restraint was discontinued on 10/7/07 8:00 AM. On 11/8/07 at 11:45 AM, the 6 West Charge Nurse and the Director of Patient Safety reviewed the record. They confirmed that a specific assessment of the continued need for restraints was not documented.  *Patient #43 was a 72 year old male with a diagnosis of Stage III multiple myeloma. He was hospitalized for malnutrition and uncontrolled pain on 10/18/07 and expired on 10/27/07. On 10/23/07 he required intubation and was transferred to the ICU.			
On 10/24/07 at 2:00 AM bilateral wrist restraints were initiated for reasons, checked from a computer list of, UnsafeOOB (unsafe out of bed), ImpCogntn (impaired cognition) and RemovLne (removing a line). These remained in place through 10/25/07 at 12:00 AM. The same restraints were reinitiated on 10/25/07 at 9:00PM and continued through 10/26/07 at 8:00 PM.			
There were unsigned doctors orders for these restraints for the dates of $10/25 - 10/27/07$ .  Nursing documentation for the same dates that restraints were in place included the following: -10/24 8:00 AM "no movement noted in any extremities, pt is chemically sedated." -10/24 12:00 PM "Physical reassessment of all parameterscompleted, and there are no changes from the previous documentation." -10/24 4:00 PM "Physical reassessment of all	The physician who was responsible for signing these orders was sent a letter from the Chief Quality and Safety Officer explaining the importance of signing daily orders for restraint. Please see Appendix D.	J. Robert Polk, MD VP, Chief Quality and Safety	12/14/07

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1. The CWOCN's activity sheets documented the CWOCN's had seen patients with pressure ulcers at the following monthly rates:

8/07: 22 patients with pressure ulcers. Of the 22 patients, 19 were identified as having hospital acquired pressure ulcers.

9/07: 17 patients with pressure ulcers. Of the 17 patients, 6 were identified as having hospital acquired pressure ulcers.

10/07: 31 patients with pressure ulcers. Of the 31 patients, 28 were identified as having hospital acquired pressure ulcers.

The hospital's FY08 SARMC Quality and Safety Plan," dated 3/15/07, stated in the "Improve Pressure Ulcer Indicator" section that the hospital was "Improving definitions and data collection tools and processes for quarterly prevalence study. Defining standards of nursing assessment and pressure ulcer prevention interventions [sic]."

The facility's quality improvement document was a "Pressure Ulcer Prevalence Report" dated 8/21/07. The report was a facility wide screening that documented whether or not the patients had a pressure ulcer. The report consisted of a grid. Each column of the grid was labeled with patient information (i.e. room number, name, age, sex, admit date, etc.) and information related to pressure ulcers (i.e. Braden score, types of pressure ulcer prevention in use, number of ulcers, etc.). Each row of the grid represented a separate patient. When asked bout the report on 11/16/07 at 9:45 AM, a CWOCN stated the report was completed one day each quarter, by completing a visual check of the patient and entering data on the grid which reflected each patient's status.

The hospital's 8/21/07 "Prevalence Report" documented there were no less than 9 patients who had pressure ulcers. Of those 9 patients who had pressure ulcers, the "Prevalence Report" documented 6 patients had developed hospital acquired pressure ulcers, which included but were not limited to the following:

The activity sheet data was not explained correctly to the surveyor and so the data quoted here is incorrect. The correct data is: 8/07 21 pressure ulcers/1387 discharges=1.5% 8 hospital acquired/1387 discharges=0.6% 9/07 18 pressure ulcers/1354 discharges=1.3% 5 hospital acquired/1354 discharges=0.4% 10/07 31 pressure ulcers/1428 discharges=2.2% 14 hospital acquired/1428 discharges=1% These results are similar to the results found during our most recent (12/11/07) prevalence study which found: Prevalence: 2 pressure ulcers/185 patients=1.1% Incidence: 0 pressure ulcers developed within 3 days Please see Appendix F for prevalence results as compared to the previous quarter. Please also see Appendix G for data comparing SARMC with Trinity Health System. Please note that SARMC is within the target range (green). The target is based on national

a. The row for Patient #24 on the 8/21/07 "Prevalence Report" stated the following:

The first 6 columns documented his room number, name, MRN, age, sex, and admission date.

The 7th column stated "Assessment Prior to Survey." A "yes" was placed in the box.

The 8th column stated "Braden Score." A "17" was placed in the box.

The 9th column stated "Time Since Last Assessment." The box stated ">12 - 24 Hours."

The 10th column stated "Pt (patient) at Risk." The box stated "Yes."

The 11th column stated "Pressure Ulcer Prevention" and was subdivided into 3 columns labeled "Yes", "No Evidence", and "Not Applicable." A check mark was placed in the "No Evidence" box.

The 12th column stated "Type of Pressure Ulcer Prevention in Use" and was subdivided into 4 columns labeled "Pressure Reducing Surface", "Repositioning", "Nutritional Support", and "Other". A check mark was placed in the column marked "Nutritional Support".

The 13th column stated "Number of Ulcers" and was subdivided into 3 columns labeled "Total", "Hospital Acquired", and "Unit Acquired". A "1" was placed in the "Total" column and the "Unit Acquired" column.

The 14th column stated "Number of Ulcers at Each Stage" and was subdivided into 5 columns labeled "Stage I", "Stage II", "Stage III", "Stage IV", and "Unstageable". A "1" was placed in the "Stage II" column.

The 15th column stated "Ulcer Location(s) (Use Loc. Nbr. On

data from NDNQI.

The quarterly prevalence study, conducted as required to participate in NDNQI, is used for ongoing PI monitoring. The data has been analyzed and actions implemented as a result. For example, in response to prevalence study data which revealed a pattern of ear redness due to oxygen tubing, tubing padding was implemented in Fall 2006 and resulted in a reduction in findings of ear skin breakdown. The prevalence studies have also resulted in identification of the following issues and improvement actions:

1. Identified that nursing staff needed more education to differentiate between skin redness due to pressure vs. excoriation and other causes of redness. In response, education on skin assessment and care was added to new hire orientation, CWOCNs began participating in unitbased ongoing chnical education, and training for prevalence study participants was standardized. In addition, all areas of redness identified during a prevalence study are assessed by the CWOCN to

figure)." The word "buttock" was placed in the box.

The 16th column stated "Patient on O2 (oxygen)" and was subdivided into 2 columns labeled "Yes", "No", and "NA". A checkmark was placed in the box under the "No" column.

The 18th column stated "Reason Patient Not Assessed" and was subdivided into 4 columns labeled "Not Available", "Patient Discharged", "Patient Refused", and "Contraindicated". The boxes were left blank for Patient #24.

In summary, the "Prevalence Report" documented Patient #24 was at risk and had developed a unit acquired, Stage II pressure ulcer on his buttocks. However, there was "No Evidence" of "Pressure Ulcer Prevention" measures being used beyond nutritional support.

Additionally, the "Integumentary/Skin" section of Patient #24's nursing notes documented "Reddened Skin...Buttocks...skin is red, blanches, barrier cream applied, instructed pt (patient) to turn to his side as much as possible." The documentation was dated 8/9/07 at 8:00 AM, 11 days prior to the "Prevalence Report." Similar information related to the area was documented in his nursing notes dated 8/12/07, 8/13/07, 8/14/07, 8/15/07, and 8/21/07. His record also documented on 8/21/07 at 3:30 PM an air bed was initiated, per suggestion of the 8/21/07 prevalence study.

The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, was not sufficient to ensure Patient #24 received timely and appropriate preventative care related to this skin integrity. The study did not document patient specific day to day data to identify specific quality indicators (i.e., the review and assessment of Patient #24's care record for compliance of repositioning, implementation and adherence to the hospital's wound and Braden scale policies and other such operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers).

b. The 8/21/07 "Prevalence Report" included a row for Patient

confirm that it is caused by pressure.

2. Identified that head-to-toe skin assessments were not consistently documented on admission and therefore, the hospital acquired rate was inflated because there was no documentation of the pressure ulcer being present on admission. As a result, we have revised the policy to clearly define that a head-totoe skin assessment and Braden risk assessment will be performed and documented on admission and daily. The EMR and paper documentation forms have been revised to facilitate this.

#25. In summary, the "Prevalence Report" documented Patient #25 was at risk and had developed a hospital acquired Unstageable pressure ulcer on his head. The report documented there was "No Evidence" of "Pressure Ulcer Prevention" measures being used.

However, Patient #25's nursing notes dated 8/9/07 at 8:00 AM documented he had developed a "1x2 cm purple pressure score" on his left buttocks and a "1x4 purple pressure sore" on his right posterior upper thigh. The notes documented that a rotation mattress was initiated on 8/9/07 at 11:00 AM.

Similar information related to the pressure areas on Patient #25's thigh and buttocks was documented in his nursing notes dated 8/10/07, 8/12/07. and 8/13/07. The nursing notes on 8/13/07 at 8:00 PM also documented he had developed skin breakdown on the back of his head. The notes stated "Area reddish purple colored approx size of quarter, Pt (patient) using head doughnut." Similar information regarding the pressure areas on his thigh, buttocks, and head was documented in his nursing notes dated 8/14/07, 8/15/07, 8/16/07, and 8/17/07.

The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospitals [performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to the review and assessment of the patient's care record for compliance of repositioning, the implementation and adherence of the hospital's wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers).

c. Patient #33's 8/11/07 nursing assessment stated "Skin Breakdown...Bottom...Protective Ointment Applied." Similar information regarding the area was documented daily in his nursing assessments dated from 8/12/07 to 8/21/07.

However, the 8/21/07 "Prevalence Report" included a row for

As mentioned above, the quarterly prevalence study, conducted as required to participate in NDNQI, is used for ongoing PI monitoring. It is not the purpose of the prevalence study to identify on a daily basis patients who have, or are at risk for, pressure ulcers. The CWOCNs receive a daily report of patients with documentation in the EMR of selected types of skin breakdown. They also receive a report of patients with low Braden scores. These lists, along with referrals from nurses and physicians, are used to create the CWOCNs' daily work lists.

SARMC has revised the Pressure Ulcer PI Plan to include the aim, goal, measures, actions, team membership and reporting structure. Please refer to Appendix H. Measures include:

- 1. Pressure ulcer prevalence as measured by quarterly NDNQI prevalence study.
- 2. Percentage of patients with hospital acquired

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Patient #33 but information related to his pressure ulcers was not included on the grid. Column 18 stated "Reason Patient Not Assessed" and an "X" was placed in the sub-column for "Contraindicated" an employee who worked in the PI department stated they did don't know why he was contraindicated.

The facility's "Pressure Ulcer Prevalence report," completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospitals performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to: the review and assessment of the patients care record for compliance of repositioning, the implementation and adherence of the hospitals wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers).

d. The 8/21/07 "Prevalence Report" included a row for Patient #23. In summary, the "Prevalence Report" documented Patient #23 was at risk and had developed a hospital and unit acquired pressure ulcer. The report documented she had developed a Stage I and Stage II pressure ulcer and that there was "No Evidence" of "Pressure Ulcer Prevention" measures being used. Further, summary documentation of the 8/21/07 "Prevalence Study" documented a Stage 1 hospital acquired pressure ulcer on her spine. However, the summary did not include documentation of the pressure area on her sacral area. The summary information was not consistent with the "Prevalence Report."

Additionally, Patient #23's nursing notes dated 8/16/07 at 1:00 PM documented she had developed "Skin Breakdown...sacrum...small open area 1"x1/4 in w/surrounding redness. Cream applied." Similar information related to the pressure area on 8/17/07, 8/18/07, 8/19/07, 8/20/07, and 8/21/07.

The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, did not provide sufficient information necessary

- Pressure Ulcers by Stage.
- 3. Percentage of patients with skin assessment and Braden scale documented within 24 hours of admission.
- Percentage of patients with skin assessment and Braden scale documented daily.
- 5. Percentage of patients with documented interventions based on Braden subscale.
- 6. Incidence of hospital-acquired pressure ulcers

These measures are consistent with the recommendations of the Institute for Healthcare Improvement's 5 Million Lives Campaign.

The following changes have been made in our data collection process in order to obtain these measures:

A daily report is sent to PI which lists each patient and includes:

 documented head to toe skin assessment Aline Lee, Director of Patient Safety and Regulatory

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to adequately assess the hospital's performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to: the review and assessment of the patients care record for compliance of repositioning, the implementation and adherence of the hospitals wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers).

On 11/19 at 2:30 PM, a hospital employee who worked in the PI department stated the hospital did retain a day to day cumulative data base of patients that developed pressure ulcers. She confirmed the PI department did not have a data base of reviewed hospital services and operations aspects of performance that could have been used to assess the process of care and could have lead to the reduction of the development of pressure ulcers. She said the hospital's PI department did not have a written plan based on cumulative data to reduce the rate of hospital acquired pressure ulcers.

The Prevalence study did not lead to documented evidence that the hospital had followed their 3/15/07 "FY08 SARMC Quality and Safety Plan," (on improving their "definitions and data collection tools and processes for quarterly prevalence study" or had defined "standards of nursing assessment and pressure ulcer prevention interventions") and the study was not used in a development of a written plan to reduce the rate of hospital acquired pressure ulcers. Further, the Prevalence study did not document patient specific day to day data to identify patient specific quality indicators (i.e., review and assessment of the patients care record for compliance of repositioning, implementation and adherence to the hospital's wound and Braden scale policies, and other such operational aspects of performance that could have lead to the development of the pressure ulcers).

The facility failed to ensure the pressure ulcer quality improvement system included sufficient information necessary to adequately assess the hospital's services, operations, and the processes of care

and Braden risk assessment within 24 hours of admission by unit  • documented head to toe skin assessment and Braden risk assessment within the last 24 hours  • Braden score for each subscale and total  • Interventions documented  • Skin breakdown documented  • Whether or not CWOCN saw the patient  This data will be compiled on a monthly basis and analyzed by the Pressure Ulcer Subcommittee of the Nursing Quality Outcomes Council. Improvement actions will be implemented based on the data results.	Compliance	
We began measuring incidence of hospital acquired pressure ulcers with the December 2007 quarterly prevalence study. As recommended by NDNQI, incidence of hospital acquired pressure ulcers are measured by reassessing all patients included in the prevalence study who are still in the	CWOCNs	12/11/07

hospital 3 days later. The 3

	related to patients' skin integrity.	day time frame is based on the average LOS.		
	2. Patient #33 was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. An incident report, dated 8/23/07, documented that on 8/22/07, the "PT (patient) with 3/4 in X 1/4 in oval skin breakdown on L (left) coccyx area, purple discoloration, and several blisters or R (right) coccyx on 8/22, skin protectant (sic) cream applied and pt (patient) repositioned on sides. Wound consult ordered. On 8/23 blisters no longer intact and 1in round and 1/4in round state I skin breakdown present. Wound nurse in to evaluate. Skin protectant (sic) cream placed w/saran wrap to prevent rubbing off."	Incident reports related to skin breakdown will be sent to the Performance Improvement Coordinator who facilitates the Pressure Ulcer Team for analysis of patterns/trends and opportunities for improvement.	Lori Sweet, RN, Risk Management	12/27/07
	An investigation related to the incident report could not be found. When asked, on 11/8/07 at 9:10 AM, an RN who was the unit manager at the time the patient had developed the pressure ulcer, stated she did not investigate the incident report.			
	On 11/8/07 at 9:30 AM, the DNS stated that incident reports are first given to the unit manager to investigate and then passed on to the PI department to analyze the information and identify reoccurring issues. He said that to the best of his knowledge, the above incident was not investigated.			
	On 11/9/07 at 2:30 PM, 2 hospital employees who worked in the PI department stated they were unaware of the incident report and confirmed the report was not used to assess the hospital's process of patient care to reduce the frequency of hospital acquired pressure ulcers.			
	The facility failed to ensure all pertinent incident information was investigated and analyzed in an effort to identify and safeguard against reoccurring issues.			
A 385	482.23 NURSING SERVICES  The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.	Please see response to A 395.		

	The CONDITION is not met as evidence by: Based on review of hospital policies, record review, and staff interviews, it was determined the hospital failed to ensure Supervising Registered Nurses provided adequate oversight and evaluation of patient care. This failure resulted in a lack of appropriate care being provided to patients in the treatment and prevention of pressure ulcers. The findings include:  1. Refer to A395 as it relates to the facility's failure to ensure registered nurses provided supervision and evaluation of patient care necessary to prevent and treat pressure sores consistent with current standards of nursing practice and hospital policies and procedures.			
A 395	A registered nurse must supervise and evaluate the nursing care for each patient.  The STANDARD is not met as evidenced by: Based on review of hospital policies, record review, and staff interviews, it was determined the hospital failed to ensure registered nurses provided supervision and evaluation of patient care necessary to prevent and treat pressure sores consistent with current standards of nursing practice and hospital policies and procedures. This failure resulted in 8 of 18 patients (3's 23, 24, 25, 33, 46, 56, 57, and 59) whose records were reviewed and had documented pressure sores, not receiving adequate care in the prevention and treatment of pressure sores. The findings include:  1. The hospital's "WOUND and PRESSURE ULCERASSESSMENT and CARE: CULTURE, IRRIGAITON AND DEBRIDEMENT" policy, revised 5/06, stated in the "Definition of and Treatment for Pressure Ulcers" section of the policy stated the following:  Stage I – "The ulcer appears as defined area of persistent redness in	The following actions have been taken in response to these finding:  1. The Braden Scale and Skin Assessment policy (See Appendix I) has been revised to include:  a. A head-to-toe skin assessment within 24 hours of inpatient admission  b. A Braden risk assessment within 24 hours of admission  c. Head-to-toe skin assessment and Braden risk assessment daily d. Addition of a section on Pediatric	Aline Lee, Director of Patient Safety and Regulatory Compliance	12/27/07

light pigmented skin, where as in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues." Suggested care and treatment of stage 1 pressure ulcers was to use moisturizing creams or protective ointment to affected areas.

Stage II – "Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater...It is shallow, moist, painful, and pink-red in color and may have superficial yellow slough.."

The care an treatment for stage 2 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressing every 24 – 48 hours.

Stage III — "Full thickness skin loss involving damage to, or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining adjacent tissue." The care and treatment for stage 3 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, loosely pack the wound with gauze and wound gel or saline and change the dressings every 24-48 hours.

Stage IV - "Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon or joint capsule)..." The care and treatment for stage 4 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, loosely pack the wound with gauze and wound gel or saline and change the dressings every 24 hours.

Non-stageable - "When necrotic tissue is present, a pressure ulcer cannot be accurately staged until the necrotic tissue is removed. Dark purple or bruised areas, over bony prominences, with intact skin may indicate deeper tissue damage."

The "Documentation" section of the policy stated staff were to "Document daily and prn the size, color, character, exudate of all

- Considerations with addition of the Modified Braden Q assessment scale for patients 5 years and younger (except neonates)
- e. Consult with CWOCN for "pre-existing, suspected, and/or newly developed areas of pressure, as needed."
- 2. The Wound and Pressure Ulcer—Assessment and Care; Culture, Irrigation, and Debridement policy (Appendix J) has been revised to update the table that describes various products and wound care techniques and their indications.
- 3. The nursing admission assessment form has been revised to allow documentation of the 6 Braden subscales rather than just the total score. (See Appendix K, page 4 of 6) The Braden Scale has been added as a

wounds.

The policy further stated "The Braden Scale is a rating scale that will be used by (hospital's name) staff to assess for pressure ulcer risk at admission and daily."

The "BRADEN SCALE for Predicting Ulcer Risk" policy revised in 9/06, and again in 11/07, stated "The Braden Scale for predicting Pressure Sore Risk is a tool that allows nurses and other health care providers to score a patient's level for developing pressure ulcers. Patients are assessed for pressure ulcer risk at admission and daily." Some recommended interventions included the following:

Low Risk Score 15-18:

Encourage patient to turn and shift position Address risk factors. Moderate Risk Score 13-14:

Supplement turning with small shifts in position. One example was to increase turning with a 30 degree foam wedge or pillows.

Provide appropriate pressure reducing support surface.

Certified Wound-Ostomy-Continence Nurse consult. High Risk Score 10-12:

Supplement turning with small shifts in position.

Provide appropriate pressure reducing support surface.

Certified Wound-Ostomy-Continence Nurse consult. Severe Risk Score less than or equal to 9:

Supplement turning with small shifts in position.

Provide appropriate pressure reducing support surface.

Certified Wound-Ostomy-Continence Nurse consult.

reference to the form. (See Appendix K, page 6 of 6)

- 4. The electronic medical record (EMR) has been revised to:
  - a. Include a prompt (in red) to perform head-to-toe skin assessment on admission and daily
  - b. Organize the intervention pick list by Braden subscale.

The frequency of patient positioning was not addressed in either the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" or the "BRADEN SCALE for Presdicting Ulcer Risk" policies. When asked about patient positioning, staff stated the following:

On 11/9/07 at 10:40 AM, a CWOCN confirmed the above policy and procedure and stated it was the hospital's best practice to turn patients at least every 2 hours.

On 11/5/07 at 1:53 PM, a nurse, who was a unit manager, stated patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning. The nurse stated that all patients' positions were to be documented every 2 hours in the EMTEK whether they could self turn or needed assistance with turning.

On 11/5/07 at 2:16 PM, a nurse, who worked at the hospital, stated all patients were to be repositioned every 2 hours if they cannot move or need assistance with repositioning. The nurse also stated that CWOCNs were to be consulted for all patients that had developed or had pressure ulcers prior to their admission. The nurse stated that patients' positioning was to be documented in the EMTEK.

The frequency of patient positioning is addressed in the Braden Scale and Skin Assessment policy (Appendix I, page 2 of 8) as an intervention when patients have a deficit in the Braden Sensory or Mobility/Activity subscales.

Education for staff regarding pressure ulcer prevention was accomplished through a trainthe-trainer approach. Trainers were identified for each unit. The unit trainers attended one of three sessions conducted by the clinical educators. At these sessions, the trainers received packets containing flyers, revised policies, a summary of the changes to the electronic medical record (EMR) or paper forms, and talking points for use at staff meetings, in-services, posters, bulletin boards, or other forms of communication. Education focused on the following key points:

1. Head to toe skin assessment and pressure ulcer risk assessment on Aline Lee, Director of Patient Safety and Regulatory Compliance Train-the-trainer sessions conducted on 12/12/07, 12/14/07, and 12/17/07. Unit education completed by 12/27/07.

On 11/5/07 at 2:16 PM, a second nurse, who worked as unit manager, stated all patients were to be repositioned every 2 hours if they could not move or need assistance with repositioning. The nurse also stated CWOCNs were consulted for all patients that had developed or had pressure ulcers prior to admission. The nurse stated that patients' positioning was documented in the EMTEK whether they could self turn or needed assistance with turning.

On 11/5/07 at 2:39 PM, a nurse who worked at the hospital stated, all patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning.

On 11/5/07 at 3:30 PM, the hospital's DNS stated all patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning.

On 11/6/07 at 9:32 AM, a CWOCN stated all patients that were identified as having a Braden scale score of 13 or less or had pressure ulcers were to be followed by a CWOCN. She stated they were responsible for assessing each patient to identify the patient's individual special needs to help prevent the development or further development of pressure ulcers including obtaining appropriate pressure reducing support surfaces, wound treatment, and staff education.

On 11/8/07 at 10:46 AM, a nurse who worked at the hospital stated that patients were to be turned every 2 hours or more if needed. The nurse stated they rotated patients from lying on their right side, to their back, then to their left side. She stated this was recorded in the "ACTIVITY Position" section of the patient's EMTEK.

- admission and daily
- 2. Documentation of skin assessment, pressure ulcer prevention measures, and pressure ulcer treatment.
- 3. Use of modified
  Braden Q scale for
  assessment of patients
  age 5 and under
  (except neonates)
- 4. Pressure ulcer prevention interventions based on Braden subscales scores rather than overall score
- 5. Referral to CWOCN. Please see Appendix L, which is an example of the educational packets given to the trainers.

To reinforce the unit-based training, daily rounds are being made on units to provide one-to-one coaching and evaluation of skin assessment, risk assessment, prevention measures, and documentation. An audit/teaching tool has been developed to standardize the rounding process. Please see Appendix M.

The facility failed to ensure patients were assisted to reposition every 2 hours and that the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION and DEBRIDEMENT" and the "BRADEN SCALE for Predicting Ulcer Risk" policy were consistently implemented as follows: Patient #33 was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. The patient was a 66 year old male that was admitted to the hospital after being found unresponsive in his home. The patient's Braden scale on 8/13/07 was 9 (severe risk: supplement turning with small shifts in position, provide appropriate pressure reducing support surface, Certified Wound-Ostomy-Continence Nurse consult). Patient #33's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 9. Additionally, the "ACTIVITY Position" section of his EMTEK documented that he had not been repositioned every 2 hours or provided supplemental turning with small shifts in position during the following dates and times: 8/11/07: right side from 10:00 PM to 2:00 AM on 8/12/07. His nursing assessment stated "Skin Breakdown...Bottom...Protective Ointment Applied.

8/12/07: left side from 2:00 AM until 10:00 AM, supine from 10:00 AM to 2:00 PM and supine from 6:00 PM to 12 midnight. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM, 12:00 PM, 6:00 PM and 8:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...Skin is reddened." His treatment flow sheet listed his Braden score as 11. 8/13/07: left side from 12 midnight to 4:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...Buttocks are reddened, no skin breakdown noted." His treatment flow sheet listed his Braden score as 9. 8/14/07: right side from 12:00 AM to 4:00 AM, supine from 4:00 AM to 2:00 PM and on his right side from 2:00 PM to 6:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...Reddened." His treatment flow sheet listed his Braden score as 11. 8/15/07: right side from 4:00 AM to 12:00 PM. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc) had occurred at 8:00 AM and 10:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...redness noted skin intact." His treatment flow sheet listed his Braden score as 10. 8/16/07: right side from 12:00 AM to 8:00 AM and supine from 6:00 PM to 4:00 AM on 8/17/07. His nursing assessment stated "Skin Breakdown...Bottom...No dressing." His

treatment flow sheet listed his Braden score as 11.

8/17/07: supine 6:00 AM to 10:00 AM and supine from 10:00 PM to 8:00 AM on 8/18/07. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM. His 8/17/07 nursing assessment stated "Skin Breakdown...Bottom...less reddened than previous day, no open areas noted." His 8/18/07 nursing assessment stated "Skin Breakdown...Bottom...No dressing. 6-in diameter of redness. Open bleeding area noted." His treatment flow sheet listed his Braden score as 17 on 8/17/07 and as 11 on 8/18/07.

The facility failed to ensure Patient #33 was appropriately reposition every 2 hours, that the Braden scale policy interventions were implemented given his continued low scores (supplement turning with small shifts in position, provide appropriate pressure reducing support surface, certified Wound-Ostomy-Continence Nurse consult) and that appropriate wound care occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24 - 48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT AND CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy.

Patient #33's medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the progression of his pressure ulcer. The "ACTIVITY Position" section of his EMR documented that he was not positioned appropriately during the following dates and times:

8/19/07: right side from 4:00 AM to 10:00 AM, supine from 10:00 AM to 10:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...No dressing, open area on R buttocks. Reddened around and on L..." His treatment flow sheet listed his Braden score as 9.

8/20/07: supine from 2:00 PM to 8:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...reddened, has two small areas that are open and occasionally bleeding, cleaned well, applied barrier cream." His treatment flow sheet listed his Braden scores as 11 and 9.

8/21/07: His nursing assessment stated "Skin Breakdown...Bottom...reddened, coccyx, has small opening noted to right buttocks, cleaned well and applied barrier cream..." Additionally, a CWOCN consult, dated 8/21/07, stated "First step mattress obtained fro comfort care." His treatment flow sheet listed his Braden score as 11 and 13.

8/22/07: His nursing assessment stated "Skin BreakdownBottom1 in blister and purple discoloration. 3/4in oval state 1 breakdown." Additionally, an 8/23/07, the "patient with 3/4 in x 1/4 in oval skin breakdown on L coccyx area, purple discoloration, and several blisters on R coccyx on 8/22, skin protectant cream applied and pt repositioned on sides. Wound consult ordered. On 8/23 blisters no longer intact and 1in round and 1/4in round stae I skin breakdown present. Wound nurse in to evaluate. Skin protectant cream placed w/saran wrap to prevent rubbing off." A Braden score was not documented on his treatment flow sheet.		

8/23/07: left side from 2:00 AM to 8:00 AM. The record		
documented supplemental repositioning (i.e., change in the angle		
of the head of the bed, etc.) had occurred at 4:00 AM. His		
nursing assessment stated "Skin		
BreakdownRectum1.5cmx2cmNo dressing Partial		
thickness skin loss blistered excoriated 1.5cmx2cm. Barrier		
cream appliedBottomNo dressing wound is excoriated inflamed large listers have opened and		
drainedRectum3cmx3cmNo dressing Partial thickness skin		
loss open blister 3cmx3cm. Barrier cream applied."		
Additionally, a CWOCN consult, dated 8/23/07, stated "Was		
not informed on 8/21 that this patient had skin breakdown		
related to being down at home. Has skin breakdown of both		
buttocks related to being down at home - now outer skin has		
sloughed and red wound base is seen. Skin protective paste is		
being applied qid. Left heel has black eschar - dry - no drainage - probably related to how he was laying on the floor at home.		
Orders written to paint the area with betadine bid and wear		
prevalon boots at all times."		
r		
His treatment flow sheet listed his Braden score as 18.		

The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours and that appropriate wound care occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or nonadherent dressing and change the dressings every 24-48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, a CWOCN was not contacted until 8/21/07 despite his low Braden scores (prior to the 8/23/07 score of 18) and having an open wound since 8/18/07. On 11/9/07 at 10:10 AM, a CWOCN confirmed the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer, per policy, until 8/21/07. His medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the CWOCN nurse consult and the continuation of open areas on his buttocks. The "ACTIVITY Position" section of his EMTEK documented that he was not positioned appropriately during the following dates and times:

8/24/07: His nursing assessment at 12:00 AM stated "Contusion/Hematoma...R Heel...4CMx2CM...Hematoma black no open skin noted bootie and barrier cream applied." His nursing assessment at 8:00 AM stated "Skin Breakdown...Bottom...Skin Breakdown...Rectum...3cmx3cm...Unchanged from documentation, cream applied and plastic wrap...Skin Breakdown...Rectum...1.5cmx2cm...Unchanged from documentation...Contusion/Hematoma...R...Heel...4CMx2CM..." His treatment flow sheet listed his Braden score as 16.

8/25/07: His nursing assessment stated the areas on his rectum continued to be open and barrier cream and plastic wrap were being used. He also had a reddened area on his buttocks that was also being treated with barrier cream and plastic wrap.. His PT notes stated he was also using Sage boots and an air mattress. His treatment flow sheet listed his Braden score a 13.

8/26/07: His nursing assessment stated "Dressing moist reinforced" and the shift summary report stated, "The areas on his bottom are very irritated from the loose stools and bleed slightly during cleaning of them..." His treatment flow sheet listed his Braden score as 10.

On 11/7/07 at 1:53 PM, an RN, who was a unit manager on the unit to which the patient was admitted, stated nursing attempted to reposition the patient but he always went back to lying on his back. She also stated the patient was incontinent of stool and urine and was often moist or wet.

On 11/5/07 at 2:16 PM, a second nurse, who worked as unit manager on the unit to which the patient was admitted, stated the patient was not able to lay on his sides because it affected his vital signs and his blood pressure would drop and this was why he was not repositioned.

8/27/07: supine from 6:00 AM to 2:00 PM. His record documented that his linens had been changed at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 10:10 AM. His nursing assessment stated "Skin Breakdown...Bottom...reddened excoriated bottom and coccyx. Barrier paste and saran wrap applied...Skin Breakdown...Rectum...3cmx3cm...reddened and excoriated barrier paste and saran wrap applied...Skin Breakdown...Rectum...1.5cmx2cm...reddened and excoriated barrier paste and saran wrap applied." His treatment flow sheet listed his Braden score a 11.

8/28/07: supine from 8:00 AM to 12:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 10:00 AM. His nursing assessment at 8:15 AM stated "Skin Breakdown...Bottom...Barrier cream with saran wrap, all the wounds are in a butterfly shape all connected together into one wound now...Contusion/Hematoma...R Heel...4cmx2cm..." His nursing assessment at 10:00 PM stated "Skin Breakdown...Bottom...Pt with State II decubitus ulcer on sacral region. Saran Wrap dressing intact. No oozing noted..."

Additionally, a CWOCN consult, dated 8/28/07 at 11:30 am, stated "coccyx remains with dark eschar over it open area scattered around on the soft tissue will continue with treatment of protective paste and plastic wrap spoke with nursing and emphasized with nursing importance of turning - right heel plantar posterior was black - soft appears to be resolving blood blister - will continue with betadine to area and prevelon boots..." His treatment flow sheet listed his Braden score as 9, 11, and 15.

On 11/9/07 at 10:10 AM a CWOCN confirmed the above documentation and stated it was the hospital's best practice to run patients at least every 2 hours. She also confirmed that if a patient's Braden scale was 9 or less, that nursing staff, per policy, should be supplementing turning with small shifts in the patient's position.

The facility failed to ensure Patient #33 was appropriately reposition every 2 hours and there was no documented evidence of supplemental turning with small shifts in position, despite the ongoing progression of his pressure ulcers. Additionally, despite the CWOCN's emphasis on the "importance of turning" the "Activity Position" section of his EMTEK continued to document he was not repositioned every 2 hours during the following dates and times:

8/29/07: right side from 2:00 PM to 6:00 PM and then supine until 10:00 PM. His record also documented he had a pad change at 2:00 PM. His nursing assessment at 12:41 AM stated "Skin Breakdown...Bottom...ointment applied, stage 2-3 ulcer bilaterally..." His nursing assessment at 3:30 PM stated "Skin Breakdown...Bottom...reddened to bilateral buttocks, left buttocks has much larger area with redness to outside and some blackness to center of wound, very scanty amount of bleeding occasionally. Repositioning frequently..." His treatment flow sheet listed his Braden score as 15. 8/30/07: His record also documented he had received a back rub at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 9:45 AM. His nursing assessment stated "Skin Breakdown...Bottom...Area showing signs of healing. No s/s of infection noted. Area cleansed with periwipe, barrier cream applied and covered with plastic wrap...Contusion/Hematoma...R heel...4cmx2cm...Skin remains intact..." His treatment flow sheet listed his Braden score as 12.

8/31/07: left side from 6:00 AM to 10:00 AM, on his right side from 10:00 AM to 2:00 PM, and on his right side again from 10:00 PM until 4:00 AM on 9/1/07. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 12:00 PM and that he received a backrub, barrier cream and his linen was changed at 2:00 AM. Additionally, a CWOCN consult, dated 8/31/07 at 3:30 PM, stated "area of dark eschar is getting smaller - red wound visible around perimeter of wound will continue with current treatment plan of skin protective paste and saran wrap..." His treatment flow sheet listed his Braden score as 15. 9/1/07: His nursing assessment stated "For wound care see treatment Flow sheet..." and his heel was floated in AFO boots. However, his treatment flow sheets did not include documentation of his wounds until 9/12/07. His treatment flow sheet listed his Braden score as 14 and 16. The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours and that his records consistently reflected his wound status and interventions. Additionally, the "ACTIVITY Position" section of his EMTEK documented he continued to not be repositioned appropriately during the following dates and times:

9/2/07: right side from 2:00 PM to 6:00 PM and supine from 6:00 PM to 10:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 4:00 PM and 8:00 PM and that his bed pad was also changed at 8:00 PM. His nursing assessment stated "Coccyx area is notable for full thickness skin breakdown with pink granular tissue, old tissue is black. Area is moist, without sys of infection, covered with transparent dressing...R heel...4cmx2cm...intact skin has 2x3 cm area with black color. Without drainage or dressing..." His treatment flow sheet listed his Braden score as 15. 9/3/07: His nursing assessment stated "Bottom...large decubitus noted w/black eschar...R heel...4cmx2cm...r heel has eschar..." His treatment flow sheet listed his Braden score as 14 and 19. 9/4/07: right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 1:30 PM. His nursing assessment stated "Bottom...left decubitis with brownish tissue, reddened and open on both cheeks, wound care done with saran wrap replaced..." His nursing assessment at 4:00 PM stated "...Bottom...bilateral ulcerations on buttocks dressing in place blackened areas noted wound service following...R (right) heel...4CMx2CM...heels remain off bed et boots in place (sic) and no pressure is on feet or heels..." His treatment flow sheet listed his Braden score as 13 and 12.

9/5/07: left side from 6:00 AM to 6:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 11:54 AM and the Occupational Therapist had assisted Patient #33 to shave and comb his hair at 2:00 PM. His nursing assessment stated "Bottom...5cm in diameter blacken circular area with superficial breakdown peripherally...R (right) heel...4CMx2CM...blackened area intact..." His treatment flow sheet listed his Braden Score as 13. 9/6/07: His nursing assessment stated "Bottom...Barrier cream placed per wound care nurse. Black eschar over 2 inch diam (diameter) area...R (right) heel...4CMx2CM...black, 1/2 inch diam. Prevalon boot intact..." His treatment flow sheet listed his Braden score as 16 and 12. 9/7/07: His nursing assessment stated "Bottom...Sacral area with area of eschar. Some slight bleeding around edges while cleaning him up. Area of coccyx appears to be healing. Area is pink with granulation...R (right) heel...4CMx2CM...Not observed..." Additionally, the CWOCN's noted, dated 9/7/07 at 4:50 PM stated "...staff instructed on wound care as he just moved to this unit..." His treatment flow sheet listed his Braden score as 17, 16, and 10.

9/8/07: His nursing assessment stated "Bottom...Pt has very large full thickness breakdown on buttock. 2 areas on the L (left) buttock and 1 on the R. (right) Largest area has necrotic tissue in the center with bleeding granulation tissue surrounding. Cleansed with sterile saline and applied polymen dressing. Other breakdown on the R (right) is smaller but (sic) still full thickness decub with granulation tissue present. MD notified...R (right) heel...4CMx2CM...has dark purple (sic) blood blister on the R (right) heel, skin is intact and dry..." His treatment flow sheet listed his Braden score as 12 and 10.

9/9/07: supine from 6:00 PM to midnight. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 PM and 10:00 PM. His nursing assessment at 8:00 AM stated "Skin Breakdown...Bottom...Dressing with small amount of dried drainage; changed and new polymen applied. Patient has full-thickness breakdown on buttocks; two areas on 1 (left) and one on R (Right). The left buttock has black necrotic tissue in center and bleeding granulation tissue surrounding. The right is full-thickness decub with granulation tissue...Contusion/Hematoma...R (Right)

Heel...4cmx2cm...blood blister to R (right) heel." Additionally, his nursing assessment at 8:00 PM stated "Reddened Skin...Nose...(checked) Dressing, clean, dry, intact..." His treatment flow sheet listed his Braden score as 11 and 12.

9/10/07: right side from 4:00 AM to 9:00 AM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM. His nursing assessment stated at 8:00 PM "Skin Breakdown...Bottom...Minimal drainage, no dressing present. Large eschar present with reddened and open skin surrounding it. No s/s (signs/symptoms) of infection...Reddened Skin...Nose...Skin reddened. Dressing clean, dry, and intact. No s/s (signs/symptoms) of infection." A Braden score was not listed on his treatment flow sheet.

9/11/07: left side from 12:00 PM to 12:00 PM on 9/12/07. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc) had occurred at 2:00 PM on 9/11/07 and 8:00 AM and 10:00 AM (during a bed bath) on 9/12/07. His nursing assessment stated "Skin Breakdown...Bottom...reddened open area to coccyx, small area of escar (sic) noted to center of wound...Contusion/Hematoma...R (right) heel...4cmx2cm...pt (patient) also has a very small blister noted to left heel...Reddened Skin...Nose...reddened, very small area that has been open but is healing." His treatment flow sheet listed his Braden score as 14 and 12.

9/12/07: right side from 12:00 PM to 6:00 PM. His record also documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:08 PM. His nursing assessment stated "Skin Breakdown...Bottom...no dressing, skin barrier applied per wound care orders. Reddened Skin...Nose... (checked). Dressing clean, dry, intact..." His treatment flow sheet listed his Braden score as 15 and 12. 9/13/07: left side from 12:00 AM to 4:00 AM, supine from 4:00 Am to 2:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 10:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...No drsg. (dressing) area is red and has so (sic) eschar that is dry. Ointment applied...Confusion/Hematoma...R (right) heel...4cmx2cm...Prevolen boots on. Small blister to left heel. No s/s (signs/symptoms) of infection...Reddened Skin...Nose...Area to bridge of nose is oozing and breakdown from BIPAP mask. Drsg (dressing) is present." His treatment flow sheet listed his Braden score as 12 and 13. 9/14/07: right side from 8:00 AM to 12:00 PM, and laying on his left side from 6:00 PM to 10:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 10:00

9/15/07: supine from 6:00 PM to 10:00 PM. His record documented he had received barrier cream and a bed pad change at 8:00 PM. His nursing assessment stated "skin Breakdown...Bottom...area has slight bleeding spots on bottom. (sic) center. (sic) of wound is black and necrotic (sic). Out side (sic) edges of wound appear to be peeling away...Reddened Skin...Nose...Area is scabbed and reddened in the midline." His treatment flow sheet listed his Braden score as 14 and 9.

9/16/07: His nursing assessment stated "Skin Breakdown...Bottom...large area on bilateral checks (sic) that are stage 3 ulcers with some areas of bleed. (sic) middle of right butt check (sic) wounds is black and necrotic...Contusion/Hematoma...R (right)
Heel...4cmx2cm...Reddened Skin...Nose...area is scabbed with large wound at the bridge of nose." His treatment flow sheet listed his Braden score as 15.

9/18/07: His nursing assessment stated "Skin Breakdown...Bottom...Black escar (sic) noted on left buttock/coccyx area, deep area open on both side...Contusion/Hematoma...R (right)
Heel...4cmx2cm...Right heel approx 1.5 inchx1 inch black circle, closed...left heel has eraser sized black area...Reddened Skin...Nose...Scabbed area - ointment applied..." His treatment flow sheet listed his Braden score as 15.

The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours. Additionally, the wound to his left heel, noted on 9/11/07, was not again documented on until 9/18/07. Further, his EMTEK under the "ACTIVITY Position" documented he continued to not be repositioned appropriately as follows:

9/19/07: His nursing assessment stated "Skin Breakdown...Bottom...(checked dressing clean, dry, intact. Breakdown has quarter-sized area of necrotic tissue in center...Contusion/Hematoma...R (right)
Heel...4cmx2cm...blood blister present in 4x2 cm area on heel. Prevalon boots on...Reddened Skin...Nose...scabbed over.
Dime-sized. Bacitracin ointment applied." His treatment flow sheet listed his Braden score as 16 and 12.

9/21/07: supine from 8:00 AM to 12:00 PM. His record also documented he had received a bed bath and linen change at 10:15 AM. His CWOCN note stated "Nose is healing well and escar (sic) is resolving. Coccyx ulcer with black escar (sic) resolving, deeper with debridement and base with yellow slough. I conservatively removed and new granular tissue is present. No odor or signs of acute infection. Notified (physician's name) of confusion with who was coming to debride wound and suggested that patient could benefit from debridement. Patient should continue air overlay if DC'd (discharged) to ECF (extended care facility). Same wound care needed. Could benefit from alginate now in wound base. It now has some depth. I wrote out these recommendations (sic) and attached to the DC (discharge) orders..." His treatment flow sheet listed his Braden score as 14.

9/22/07: left side from 12:00 AM to 8:00 AM and on his right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:15 PM. His nursing assessment stated "Wound base is covered greater than 50% with thick, yellow slough. Unknown if discharge will take place on Sun or Mon." His treatment flow sheet listed his Braden score as 15 and 14.

9/23/07: A physician's progress note stated "Surgery I have examined Pt's (patient's) sacral decubitus ulcer. It seems as though another surgeon was initially consulted to evaluate this problem. Currently, my opinion is that the wound looks reasonable clean with granulation noted. I would not be interested in debriding the wound @ this time, as less aggressive measures are working." His treatment flow sheet listed his Braden score as 16.

9/24/2007: His nursing assessment stated "...Coccyx large red to pink open area with no s/s (signs/symptoms) of infection, signs of healing noted, dressing changed per orders...Contusion/Hematoma...R (right)
Heel...4cmx2cm...No c/o (complaints of) tenderness, heel in bootie and floated...Reddened Skin...Nose...Brown scab noted on bridge of nose, no s/s (signs/symptoms) of infection or drainage noted...Padding placed under BiPAP mask." A CWOCN note stated "Nose eschar continues with no redness decreasing in size - dry. Right heel eschar is dry - no drainage - to be transferred today..." His treatment flow sheet listed his score as 13.

9/25/07: His nursing assessment stated "Skin Breakdown...Bottom...Dressing intact, white thick drainage noted at center of wound, edges pink to red with evidence of healing noted...R (right) heel...4cmx2cm..." His treatment flow sheet listed his Braden score as 15.

9/26/07: His nursing assessment stated "Skin Breakdown...Bottom...Dressing clean, dry, intact. Wound edges pink to red. Small amount of thick white drainage in center of wound. No s/s (signs/Symptoms) of infection...R (right) heel...4cmX2cm...Reddened Skin...Nose...No dressing; small scab present, no s/s (signs/symptoms) of infection. Evidence of healing present. Bacitracin ointment applied." A Braden score was not recorded on his treatment flow sheet.

9/27/07: "Skin Breakdown...Bottom...Not assessed at this time." His treatment flow sheet listed his Braden score as 14. 9/28/07: Patient #33 was discharged to an Extended Care Facility.

9/28/07: Patient #33 was discharged to an Extended Care Facility. When asked about Patient #33's records, the CWOCN stated on 11/9/07 at 10:10 AM, the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer, per policy, until 8/21/07 and she confirmed the EMTEK documentation.

Patient #33 was not provided with appropriate and timely care for his pressure wounds. The facility's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" and "BRADEN SCALE for Predicting Ulcer Risk" policies were not implemented. Patient #33's record did not include documentation that he was consistently reposition every 2 hours with small shifts in position and his records did not consistently reflect his wound status and interventions. The Supervising RN failed to ensure Patient #33's care was appropriately evaluated on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy.

Patient #25 was admitted to the hospital on 8/7/07 and was discharged on 8/17/07. The patient was a 74 year old male who had an aortic valve replacement and coronary artery bypass. His medical record did not include documentation that he was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy as follows:

8/7/07: His treatment flow sheet listed his Braden score as 22 prior to surgery and 14 after surgery.

8/8/07: His treatment flow sheet listed his Braden score as 12 and 15.

8/9/07: The "ACTICITY Position" section of his EMTEK documented no evidence that he had been repositioned every 2 hours. The EMTEK documented that he was supine from 4:00

AM to 8:00 AM and from 10:00 AM to 4:00 PM. His record		
documented supplemental repositioning (i.e., change in the angle		
of the head of the bed, etc.) had occurred at 6:00 AM, 11:00 AM		
and 12:00 PM and that a rotation mattress was initiated at 11:00		
AM. His treatment flow sheet listed his Braden score as 14 and		
17. His nursing notes stated he had a skin impairment of		
reddened skin on his left buttocks due to pressure. The notes		
documented at 8:00 AM, "1x2 cm purple pressure sore, skin		
intact, protective barrier cream applied." His nursing notes also		
documented he had a skin impairment of reddened skin on his		
right posterior upper thigh due to pressure. The notes		DALLALAS
documented at 8:00 AM, "No dressing 1/4 purple pressure sore,		
skin intact, protective barrier cream applied." His nursing		
assessment at 6:25 PM stated "Pressure sores on back side,		
intact, change out bed to specialty one w/rotation feature"		

8/9/07: The "ACTICITY Position" section of his EMTEK documented no evidence that he had been repositioned every 2 hours. The EMTEK documented that he was supine from 4:00 AM to 8:00 AM and from 10:00 AM to 4:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 6:00 AM, 11:00 AM and 12:00 PM and that a rotation mattress was initiated at 11:00 AM. His treatment flow sheet listed his Braden score as 14 and 17. His nursing notes stated he had a skin impairment of reddened skin on his left buttocks due to pressure. The notes documented at 8:00 AM, "1x2 cm purple pressure sore, skin intact, protective barrier cream applied." His nursing notes also documented he had a skin impairment of reddened skin on his right posterior upper thigh due to pressure. The notes documented at 8:00 AM, "No dressing 1/4 purple pressure sore, skin intact, protective barrier cream applied." His nursing assessment at 6:25 PM stated "...Pressure sores on back side, intact, change out bed to specialty one w/rotation feature..."

8/10/07: His treatment flow sheet listed his Braden score as 10. His nursing notes at 8:00 AM stated "left buttocks...Skin intact but reddened" and "upper thigh...Skin intact."

8/11/07: His treatment flow sheet listed his Braden score as 12. His 8:00 AM nursing notes stated "left buttocks...Skin intact but reddened" and "upper thigh...2 inch area of dark red skin, skin intact."

8/12/07: His treatment flow sheet listed his Braden score as 15. His 7:30 AM nursing notes documented "left buttocks...Approximately the size of a pencil eraser, opened with slight bleeding noted" and "upper thigh...irregular oval shaped reddened pressure area noted. Skin intact. Approx 1/2 inch in length." 8/13/07: His treatment flow sheet listed his Braden score as 18. His 8:00 AM, nursing notes documented "left buttocks...area is covered with barrier cream. Area is beginning to heal" and "upper thigh...no dressing, covered with barrier cream." Additionally, at 8:00 PM, his nursing notes documented he had a skin integrity impairment of skin breakdown on the back of his head. The notes stated "Area reddish purple colored approx size of quarter, Pt (patient) using head doughnut." Patient #25's record did not include documentation that staff covered the open wound on his left buttocks with a foam or non-adherent dressing every 24=48 hours per the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE: CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, there was no documented evidence that the CWOCN was consulted per the "BRADEN SCALE for Predicting Ulcer Risk" policy due to his low Braden scores (i.e., 13 or below as documented on 8/8, 8/10 and 8/11/07). His medical records further documented the following: 8/9/07: The "ACTIVITY Position" section of his EMTEK documented no evidence that he had been repositioned every 2

hours. The EMTEK documented that he was supine from 4:00 AM to 8:00 AM and from 10:00 AM to 4:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 6:00 AM, 11:00 AM and 12:00 PM and that a rotation mattress was initiated at 11:00 AM. His treatment flow sheet listed his Braden score as 14 and 17. His nursing notes stated he had a skin impairment of reddened skin on his left buttocks due to pressure. The notes documented at 8:00 AM, "1x2 cm purple pressure sore, skin intact, protective barrier cream applied." His nursing notes also documented he had a skin impairment of reddened skin on his right posterior upper thigh due to pressure. The notes documented at 8:00 AM, "No dressing 1/4 purple pressure sore, skin intact, protective barrier cream applied." His nursing assessment at 6:25 PM stated "Pressure sores on back side, intact, change out bed to specialty one w/rotation feature"		
His nursing notes at 8:00 AM stated "left buttocksSkin intact but reddened" and "upper thighSkin intact."		
8/11/07: His treatment flow sheet listed his Braden score as 12. His 8:00 AM nursing notes stated "left buttocksSkin intact but reddened" and "upper thigh2 inch area of dark red skin, skin intact."		
8/12/07: His treatment flow sheet listed his Braden score as 15. His 7:30 AM nursing notes documented "left buttocksApproximately the size of a pencil eraser, opened with slight bleeding noted" and "upper thighirregular oval shaped reddened pressure area noted. Skin intact. Approx 1/2 inch in length."		
8/13/07: His treatment flow sheet listed his Braden score as 18. His 8:00 AM, nursing notes documented "left buttocksarea is covered with barrier cream. Area is beginning to heal" and "upper thighno dressing, covered with barrier cream." Additionally, at 8:00 PM, his nursing notes documented he had a skin integrity		

impairment of skin breakdown on the back of his head. The notes stated "Area reddish purple colored approx size of quarter, Pt (patient) using head doughnut."

Patient #25's record did not include documentation that staff covered the open wound on his left buttocks with a foam or non-adherent dressing every 24=48 hours per the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE: CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, there was no documented evidence that the CWOCN was consulted per the "BRADEN SCALE for Predicting Ulcer Risk" policy due to his low Braden scores (i.e., 13 or below as documented on 8/8, 8/10 and 8/11/07). His medical records further documented the following:

8/14/07: His treatment flow sheet listed his Braden score as 17. His 8:00 AM, nursing notes stated "left buttocks...Reddened and wound is open and appears to be in early stages of healing...barrier applied" and "upper thigh...Reddened/purplish in color barrier applied. Skin appears to be intact." Additionally, the notes documented "back of head...Remains reddish/purple in color. Skin is intact. Donut (sic) remains in place."

8/15/07: His treatment flow sheet listed his Braden score as 17 and 19. His 8:00 AM nursing notes stated "left buttocks...No dressing, remains reddened, barrier applied" and "upper thigh...No dressing." Additionally, his nursing notes documented "back of head...Remains intact, purplish in color."

8/16/07: His treatment flow sheet listed his Braden score as 20. His 8:00 AM nursing notes stated "left buttocks...No dressing, surrounding skin red, wound yellow, no drainage. Skin barrier ointment prn." Additionally, the notes stated "back of head...No dressing, wound scabbed over, no drainage."

8/17/07: The "ACTIVITY Position" section of the Treatment Flow sheet documented Patient #25 was sitting in a chair from 4:00 AM until 6:00 PM. Documentation the patient was

repositioned every 2 hours was not present in the patient's record. The notes documented he walked 140 feet at 12:00 PM and 280 feet at 4:00 PM. A Braden score was not listed on his treatment flow sheet. His 8:00 AM nursing notes documented "upper thigh...scabbed area approximately 3 cm diameter; no s/s (signs or symptoms) infection."

Despite developing no less than 3 pressure ulcers, Patient #25's medical records did not include documented evidence that the CWOCN was consulted. On 11/9/07 at 9:40 AM, a CWOCN confirmed the CWOCN department was not consulted by nursing staff about Patient #25's pressure ulcers.

Patient #25 was not provided with appropriate and timely care for his pressure wounds. The facility's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" and "BRADEN SCALE for Predicting Ulcer Risk" policies were not implemented in response to Patient #25's Braden scores and his development of pressure ulcers. Further, Patient #25's record did not include documentation that he was consistently reposition every 2 hours with small shifts in position. The Supervising RN failed to ensure Patient #25's care was appropriately evaluated on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy.

Patient #24 was admitted to the hospital on 8/2/07 and was discharged on 8/23/07. The patient was a 80 year old male who had a history of underlying coagulopathy related to alcoholic hepatitis. At the time of his admission, he had a Braden scale score of 14 (Moderate Risk Score, supplement turning with small shifts in position such as increased turning with a 30 degree foam wedge or pillows, provide appropriate pressure reducing support surface such as a specialty mattresses or specialty padded boots). Patient #24's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. Additionally, his medical record documented the following:

8/9/07: At 8:00 AM the "Integumentary/Skin" section of his

 nursing notes documented "Reddened SkinButtocksskin is red, blanches, barrier cream applied, instructed pt (patient) to turn to his side as much as possible."	
8/12/07: At 4:30 PM the "Integumentary/Skin" section of his nursing notes documented "Reddened	
SkinButtocksReddened, position shifted." At 8:00 PM the notes documented "reddened area on coccyx placed on left side encouraged to stay if possible." At 10:00 PM the notes stated	
"placed on left side but changes positions" and at 3:00 AM the notes stated "assisted to left side pillows placed to keep of (sic) coccyx area."	
8/13/07: At 8:00 AM the "Integumentary/Skin" section of his nursing notes documented "reddened area noted buttocks area with skin breakdown, no drainage."	
8/14/07: At 8:00 PM the "Integumentary/Skin" section of his nursing notes documented "coccyx is reddened (sic). No s/s (signs/symptoms) of breakdown."	
 8/15/07: At 12:00 AM the "Integumentary/Skin" section of his nursing notes documented "Coccyx is red but intact. Pt (patient) will not lie on his sides so is on his back all the time." At 8:00 AM the notes documented "Coccyx (sic) is red, dry and intact. Pt.	
(Patient refuses to lie on his sides."	
8/21/07: At 11:18 AM the "Integumentary/Skin" section of his nursing notes documented "Pt has 2 small areas of breakdown on coccyx. Wound care nurse aware. Airbed and xenaderm ordered."  At 4:00 PM the notes documented "Two small areas of break	
down. Xenaderm applied and pt (patient) turned on left side."  Additionally, the 8/21/07 "Prevalence Report" documented	
Patient #24 was at risk and had developed a unit acquired, stage 2 pressure ulcer on his buttocks. However, there was "No Evidence" of "pressure Ulcer Prevention" measures being used	
 beyond nutritional support according to the report. His nursing assessment further stated at 3:30 PM an air bed was initiated, per	

suggestion of the 8/21/07 prevalence study and a CWOCN note at 7:45 AM stated xenaderm ointment was to be used twice daily and as needed and the patient was to be assisted or reminded to run every two hours.

8/22/07: At 12:00 AM the "Integumentary/Skin" section of his nursing notes documented "Breakdown on (sic) Right Buttock (sic), dime size, blanches at 3 seconds, pink and skin is broken at surface. Left buttock is pink and blanches well, skin intact, Xenoderm applied to both sites." At 8:00 AM the notes stated "Small open area on right coccyx. Redness over several inch area, right and left coccyx. Xenaderm being used."

8/23/07: Patient #24 was discharged from the hospital. Patient #24's record did not contain documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. He was not provided with an appropriate pressure reducing support surface as per policy until 8/21/07. On 11/9/07 at 9:10 AM, a CWOCN nurse confirmed the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer until 8/21/07, the day of the prevalence study. The nurse also confirmed the above documentation.

The Supervising RN failed to ensure Patient #24 received appropriate preventative care which was consistent with the Braden scale policy interventions.

Patient #23 was admitted to the hospital on 8/16/07 and was discharged on 8/23/07. The patient was an 87 year old female who had a ground level fall and had a history of degenerative joint disease of the spine and hip. She also had a history of diabetes with chronic renal insufficiency. Her medical record documented she did not receive wound care in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION and DEBRIDEMENT" policy as follows:

8/16/07: At 1:00 PM EMTEK notes documented "Skin Breakdown...sacrum...small open area 1inx1/4 in w/surrounding

redness. Cream applied." 8/17/07: At 8:00 PM EMTEK notes documented barrier cream was applied. 8/18/07: At 8:00 PM EMTEK notes documented "Skin Breakdown...sacrum...Red with no drainage, barrier applied no dressing. 8/19/07: At 8:00 AM EMTEK notes documented no breakdown noted. However, EMTEK notes at 8:00 PM documented "Skin Breakdown...sacrum...Healing without s/s (signs/symptoms) of infection." 8/20/07: At 8:00 AM EMTEK notes documented "Skin breakdown...sacrum...reddened, skin intact." 8/21/07: At 8:00 AM EMTEK notes documented "skin breakdown...sacrum...blanchable half dollar sized red area on left upper buttock." Additionally, the hospital's 8/21/07 "Prevalence Report" documented Patient #23 was at risk and had developed a hospital and a unit acquired pressure ulcer. The report documented she had developed a stage 1 and a stage 2 pressure ulcer and that there was "No Evidence" of "Pressure Ulcer

Prevention" measures being used. However, summary documentation of the 8/21/07 "Prevalence Study" documented a stage 1 hospital acquired pressure ulcer on her spine. However, the summary did not include documentation of the pressure area on her sacral area.

8/22/07: At 8:00 PM EMTEK notes documented "Skin breakdown...sacrum...stage 2 coccyx (sic) area, open to air, no drainage."

8/23/07: Patient #23 was discharged.

Patient #23's record did not contain consistent documentation related to her skin integrity. Additionally, there was no

documented evidence that nursing staff followed the hospital's policy in caring for Patient #23's stage 2 pressure ulcer (cleansing with normal saline, using skin prep, applying barrier cream twice daily, and covering with a foam or non-adherent dressing) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Further, there was no documented evidence that the CWOCN Nurse was consulted regarding the open wound.

On 11/9/07 at 9:30 AM, a CWOCN nurse confirmed the CWOCN department was not consulted by nursing staff about the patient's pressure ulcer.

The Supervising RN failed to ensure Patient #23 received appropriate care which was consistent with the WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy.

Patient #57 was admitted to the hospital on 9/16/07 and was discharged on 10/2/07. The patient was a 67 year old female who had a history of amyloidosis and end stage renal disease managed with peritoneal dialysis. Her medical record did not include documentation that she was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy as follows:

The "Integumentary/Skin" section of her nursing assessments, dated 9/16/07 to 9/22/07, documented her skin was warm, dry and of normal color. Her Braden score for 9/20/07 was 19 and her 9/21/07 Braden scores were 19 and 18. Her record documented the following:

9/22/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated "...Skin Breakdown...buttocks...Area is reddened. Pea

sized scabbed area to coccyx. No s/s (signs/symptoms) of infection noted. Will order (sic) wound care consult."

9/23/07: Her treatment flow sheet listed her Braden score as 16. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM"...Skin Breakdown...buttocks...Buttocks is reddened with dime sized scabbed area to coccyx. No s/s (signs/symptoms) of infection."

9/24/07: Her treatment flow sheet listed her Braden score as 16. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...Skin around scrape is inflamed, center of wound is yellow/white...Reddened Skin...R (right) and L (left) heels...Skin on heels is red but blanches." A CWOCN note at 1:43 PM stated "stage III of buttocks - has open red and yellow slough areas of bilateral buttocks and coccyx area. 6x6 cm - no depth to it - patient can turn self. Has sitter. Criticaid applied to the area - orders written to apply tid (three times daily) and prn (as needed). Turn side to side every 2 hours..."

9/25/07: Her treatment flow sheet listed her Braden score as 14. The "Integumentary/Skin" section of her nursing assessment stated at 9:00 AM, "...Skin Breakdown...buttocks...No dressing, stage II pressure ulcer, treating with soap and water cleanse and skin protectant cream..." The assessment also stated "...Reddened Skin...R (right) and L (left) heels...No dressing, skin is red, slightly boggy, no signs of further breakdown..."

9/26/07: Her treatment flow sheet listed her Braden score as 16 and 12. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...Buttocks is red. Two areas of yellow. Wound care to see." The assessment also stated "...Reddened Skin...R (right) and L (left) heels...red, will elevate..." At 4:00 PM, the "Integumentary/Skin" section of her nursing assessment stated "...Reddened Skin...R (right) and L (left) heels...Slightly reddened. Will float heels." Additionally, a CWOCN note, dated 9/26/07 at 5:30 PM, stated "pt (patient) placed on first step mattress. She is

unable to attain a position of comfort on standard hospital mattress per staff RN"		
9/27/07: Her treatment flow sheet listed her Braden score as 14 and 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "Skin BreakdownbuttocksArea reddened, no s/s infection" The assessment also stated "Reddened SkinR and L heelsArea reddened, no s/s breakdown, heels elevated" At 8:00 PM, the "Integumentary/Skin" section of her nursing assessment stated "Skin BreakdownbuttocksSkin is red with open area with little to no drainage. Wound cleaned and treated with topical cream" The assessment also stated "Reddened SkinR and L heelsSkin remains red, ted hose replaced"		
9/28/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "Skin Breakdownbuttocksreddened area with yellow center noted to coccyx, area cleansed and ointment applied" The assessment also stated "Reddened SkinR and L heelsreddened"		
9/29/07: Her treatment flow sheet listed her Braden score as 17 and 14. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 PM, "Skin Breakdownbuttocksskin is red with little to no drainage from open area."		
9/30/07: Her treatment flow sheet listed her Braden score as 17. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 PM, "Skin BreakdownbuttocksArea reddened with yellow noted to center, area cleaned and topical cream applied" The assessment also stated "Reddened SkinR and L heelsreddened, elevated off bed"		
10/1/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 PM, "Skin Breakdownbuttocks(checked)		

Dressing clean, dry, intact..." The assessment also stated "...Reddened Skin...R and L heels...reddened..." Additionally, a CWOCN note at 1:57 PM stated "Patient with open skin breakdown of the buttocks - yellow slough and red open areas - applied criticald with antifungal to the area - covered with saran wrap to keep it on the skin..."

10/2/07: Patient 57 was discharged from the hospital. Despite documentation that a wound consult was to be ordered on 9/22/07, Patient #57 was not seen by the CWOCN until 9/24/07. In the interim, the patient's EMTEK did not document nursing had followed hospital polices and cleansed the pressure ulcer with normal saline, used skin prep around wound edges, loosely packed the wound with gauze and wound gel or saline and changed with dressings every 24-48 hours.

The Supervising RN failed to ensure Patient #57 received appropriate care which was consistent with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy.

Patient #59 was admitted to the hospital on 10/29/07 and discharged on 11/5/07. The patient's History and Physical, dictated at 4:35 PM on 10/29/07, stated the patient was a 94 year old female with a history of coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, moderate dementia, status post pacemaker, and a history of TIA's. She presented to the ED and was admitted due to acute shortness of breath. The history and physical stated Patient #59 also had recent admissions to the hospital in August and September for supposed CHF exacerbations. It also noted the patient's right leg was bandaged due to a previous wound on the right shin. A Treatment Flow sheet in the patient's record documented a Braden scale score of 13 at 6:00 PM on 10/29/07.

The patient's EMTEK under the ACTIVITY Position section did not contain documented evidence the patient had been repositioned every 2 hours or was provided supplemental turning with small shifts in position during the following dates and times: 10/29/07: supine from 5:45 PM to 10:00 PM and remained supine from being repositioned at 10:00 PM until 10/30/07 at 6:00 AM. At 6:00 PM an RN documented in the Assessments' Notes section of the patient's record "Integrity Impairment (Skin Breakdown)., R lower calf: Dressing clean, dry, intact. Not assessed at this time." RN documentation in the same section of the patient's record at 8:00 PM stated "Integrity Impairment (Skin Breakdown)., R lower calf: Dressing clean dry intact."

10/30/07: supine from 6:00 AM to 2:00 PM. An 8:00 AM RN nursing note stated the bandage was removed from the wound on the patient's right calf to find green ointment in the wound. No further information regarding the wound was documented by the RN. Also at 8:00 AM the patient's Treatment Flowsheet documented a Braden Scale score of 16. A CWOCN nursing note, at 2:00 PM stated "patient known to service from previous hospitalization - has an open wound on back of left calf - spoke with center for wound healing and hyperbaric medicine state that the treatment plan was a wound VAC with unna boot - when dressing removed panafill was in place on a exudry - spoke with nurse at (care center patient was admitted from) states that the wound VAC was stopped because of pain and orders were obtained, they believed, from their resident physician - will place wound gel on patient at this time with gauze dressing - and allevyn foam-wrap with kerlix."

10/30/07: as sitting in a chair 4:00 PM to 8:00 PM. Hygiene activities and a linen change were noted on the patient's Treatment Flow sheet at 4:00 PM. An RN nursing note documented at 8:00 PM that the dressing on Patient #59's calf wound was clean, dry, and intact.

10/31/07: supine from 11:00 AM to 2:02 PM, at which time a PT assessment was completed and on the right from 8:00 PM to 12:00 AM 11/1/07. On 10/31/07 at 12:00 AM an RN nursing note stated Patient #59's gown and bedding were wet from a leak in her foley catheter. At 8:00 AM an LPN nursing note indicated the dressing on the patient's calf wound was clean, dry, and intact. A

Braden Scale score of 16 was also documented in the Treatment Flowsheet at the same time. An LPN documented an assessment of Patient #59's skin integrity at 5:30 PM. The assessment included a new pressure sore "...Nickel sized purple, and reddened area to buttocks, skin breakdown. Pt turned off of buttocks and advise to stay off of her buttocks. Skin is intact and no s/s of infection noted. Pt will be turned every 2 hours." The skin breakdown on the patient's buttocks was also noted by an LPN in a nursing note at 7:28 PM and an RN nursing note at 8:00 PM.

The only documentation of the status (size, shape) of Patient #59's calf wound was found in an LPN nursing note on 10/31/07 at 3:00 PM. The note stated "Wound is larger than a silver dollar in size, no s/s of infection noted with some bloody, serous drainage on the old dressing."

11/1/07: supine from 12:00 AM to 6:00 AM and supine from 12:00 PM to 2:45 PM and again from 10:00 PM to 8:00 AM on 11/2/07. An RN nursing note at 10:05 PM indicated the skin breakdown on the patient's calf had a dressing that was clean, dry, and intact and the skin breakdown on her buttocks was described as "Area reddened. No sign of open skin." A PT note at 2:45 PM stated the patient refused PT in the morning due to fatigue, but participated in the afternoon. The PT note began by stating "Pt supine..." An RN note at 8:00 PM stated the same for the calf wound and stated the buttocks wound had no dressing and was dry and red. A Braden Scale score of 15 was also documented on the patient's Treatment Flow sheet at 8:00 PM.
4:00 AM on 11/3/07, however, the patient refused a position change.

11/3/07: supine at 12:00 PM and there was no further documentation of a different position until 2:00 PM on 11/4/07. A Braden Scale score of 14 was documented, at 8:00 AM and 8:00 PM on 11/3/07, on the Treatment Flow sheet section of the patient's record. PT documentation at 3:54 PM indicated the patient refused AM and PM PT due to fatigue.

11/4/07: left side at 4:00 PM and there was no further

documentation of a different position until 12:00 AM on 11/5/U/. A Braden Scale score of 11 was documented on the patient's Treatment Flow sheet at 8:00 AM. A nursing note at the same time documented the calf wound as having a clean, dry, and intact dressing and the buttocks wound as having redness and xenaderm applied. At 8:00 PM a nursing note documented the dressing on the calf wound was changed and the buttocks wound described as reddened and xenaderm applied. The one PT note documented for the day at 2 PM stated the patient declined PT due to fatigue and that the patient had thoracentesis earlier in the day.

11/5/07: A Braden Scale score of 10 was documented at 8:00 AM. A PT note at 9:30 AM stated Patient #59 participated in PT at that time. Patient #59 was discharged to a nursing facility at 4:15 PM with comfort measures in place.

On 11/9/07 at 10:40 AM, a CWOCN nurse confirmed the above documentation and stated it was the hospital's best practice to turn patients at least every 2 hours. The hospital failed to ensure Patient #59 was provided with services necessary to prevent skin breakdown and that the status of her wounds was consistently documented to monitor healing or lack thereof.

Note: A395 continued at A9999 CLOSING COMMENTS

CONTINUED FROM:

a395: 482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient.

Patient \$56 was a 23 year old male. He was admitted on 8/28/07 with paraplegia following a motorcycle accident. He was transferred to a rehabilitation unit on 9/27/07.

His medical record did not include documentation that he was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, his EMR under "ACTIVITY Position" did not document evidence that he had been repositioned every 2 hours or was provided

_	supplemental turning with small shifts in position during the following dates and times:		
	8/28/07: His treatment flow sheet listed his Braden score as 10.		
	8/29/07: His treatment flow sheet listed his Braden score as 8 and 10.		
	8/30/07: His treatment flow sheet listed his Braden score as 10, 9 and 9.		
	8/31/07: His treatment flow sheet listed his Braden score as 7.		
	9/1/07: His treatment flow sheet listed his Braden score as 13. Position documented as supine from 10:00 AM until 10:00 PM.		
	9/2/07: His treatment flow sheet listed his Braden score as 11 and 10. Position documented as supine from 4:00 AM until 9:56 AM when PT did passive exercise.		
	9/3/07: His treatment flow sheet listed his Braden score as 11 and 13.		
	9/4/07: His treatment flow sheet listed his Braden score as 11 and 11. Position documented as supine from 4:00 AM until 10:00 AM and again supine from 2:00 PM until 10:00 PM.		
	9/5/07: His treatment flow sheet listed his Braden score as 14 and 12.		
	9/6/07: His treatment flow sheet listed his Braden score as 14 and 11.		
	9/7/07: His treatment flow sheet listed his Braden score as 12 and 10.		
	9/8/07: His treatment flow sheet listed his Braden score as 11 and 12. Position documented as on right side from 6:00 PM until 10:00 PM.		

9/9/07: His treatment flow sheet listed his Braden score as 13. Position documented as supine from 4:00 PM until 2:00 AM on 9/10 with supplemental repositioning (not turning) at 6:00 PM and 10:00 PM.

9/10/07: His treatment flow sheet listed his Braden score as 15. Position documented as supine from 4:00 AM until 12:00 PM.

9/11/07: His treatment flow sheet listed his Braden score as 12 and 13. Position was documented as supine from 2:00 AM until 8:00 AM. He was on his right side from 8:00 AM until 11:00 AM when PT transferred him to the chair. He sat in the chair from 12:00 PM until 6:00 PM. Position documented as supine from 8:00 PM until 12:00 AM. He refused repositioned at 10:00 PM.

9/12/07: His treatment flow sheet listed his Braden score as 12. Position documented as supine from 12:00 AM until 10:00 AM. He refused repositioning at 4:00 AM. He was in the chair from 10:00 AM until 6:00 PM.

9/13/07: His treatment flow sheet listed his Braden score as 13. Position documented as right side from 2:00 AM until 8:00 AM. Position documented as supine from 8:00 AM until 1:30 PM when PT did range of motion exercises. Continued to remain supine until 8:00 PM.

9/14/07: His treatment flow sheet listed his Braden score as 11. Position documented as supine from 2:00 AM until 10:00 AM when supplemental repositioning was done. Continued supine until 12:00 PM. Position documented as left side from 12:00 PM until 4:00 PM. Position documented as supine from 4:00 PM until 12:00 AM on 9/15 when the head of the bed was lowered.

9/15/07: His treatment flow sheet listed his Braden score as 12. Position documented as left side from 12:44 AM until 11:22 AM when PT did range of motion exercises. Position documented as supine from 12:00 PM until 4:445 PM when PT transferred him to the chair. Position continued to be documented as supine until

12:00 AM on 9/16. He refused repositioning at 10:00 PM. 9/16/07: His treatment flow sheet listed his Braden score as 13. Position documented as supine from 4:00 AM until 10:00 AM with supplemental repositioning (not turning) at 8:00 AM. Position documented as right side from 10:00 AM until 2:56 PM when PT transferred him to the chair. No position was documented until 8:00 PM. Position documented as supine from 8:00 PM until 12:00 AM on 9/17. 9/17/07: His treatment flow sheet listed his Braden score as 12. Position documented as left side from 12:00 AM until 8:00 AM. He was up in the chair from 10:00 AM until 6:00 PM. 9/18/07: His treatment flow sheet listed his Braden score as 9. Position documented as supine from 12:00 AM until transferred to the chair by PT at 1:10 PM. He refused to turn at 4:00 AM and 10:00 AM. 9/19/07: His treatment flow sheet listed his Braden score as 12. Position documented as supine from 12:00 AM until PT transferred him to the chair at 3:00 PM. Position documented as in chair until 10:00 PM. He refused repositioning at 12:00 AM and 4:00 AM. 9/20/07: His treatment flow sheet listed his Braden score as 12. Position was documented as supine from 12:00 AM until 10:00 AM. He refused turning at 2:00 AM. Supplemental repositioning was done at 4:00 AM and 8:00 AM. Nursing notes at 8:00 AM document "Breakdown noted to coccyx. Area the size of a quarter. Skin is broken." 9/21/07: His treatment flow sheet listed his Braden score as 17.

9/21/07: His treatment flow sheet listed his Braden score as 17. Nursing notes document at 8:00 AM, "Skin Breakdown, Buttocks: No dressing". CWOCN intervened at 8:30 AM and ordered "smith and nephew dimeticone skin protective paste on area..." Further CWOCN documentation noted, "...patient has area of eschar on coccyx..." At 2:00 PM nursing documentation was, "Skin Breakdown, Buttocks: Cream applied; wound appears to be

healing without infection." At 8:00 PM nursing documentation was, "Skin Breakdown, Buttocks: No dressing".

9/22/07: His treatment flow sheet listed his Braden score as 15. Position documented as supine from 6:00 AM until 12:00 PM. Position documented as supine from 2:00 PM until 10:00 PM with supplemental repositioning (not turning) at 2:00 PM and 4:00 PM and passive range of motion exercises by PT at 3:21PM. Nurses notes document, "Skin Breakdown, Buttocks: turned to left side. Cream applied to sore" at 12:00 AM and at 8:00 PM. "Skin Breakdown, Buttocks: Healing without s/s of infection."

9/23/07: His treatment flow sheet listed his Braden score as 11. Position was documented as supine from 2:00 AM until 8:00 AM and up in the chair from 4:08 PM until 8:00 PM. Nurses notes documented at 8:00 AM, "Skin Breakdown, Buttocks: Skin broken wound bed red, size of quarter. Peri wound skin appears necrotic." At 6:57 PM nurses documented, "Open area to sacrum, pt turned, barrier cream applied". At 8:00 PM nurses documented, "Skin Breakdown, Buttocks: No dressing wound is dark red/purple in color. barrier cream applied per ET orders".

9/24/07 No Braden scale was assessed for this day. Position documented as left side from 4:00 AM until 10:00 AM and supine from 10:00 AM "Skin Breakdown, Buttocks: Necrotic area around open breakdown. Barrier cream applied, pt turned." At 8:00 PM nursing documentation included "Skin breakdown, Buttocks: Darkened area at coccyx appears to be healing, no s/s of infection, barrier cream applied per ET orders". CWOCN consult on this day documents at 4:00 PM, "f/u to Friday visit eschar still present small amount lifting on left side of the wound - will continue with smith and nephew dimecoine skin protection".

9/25/07: His treatment flow sheet listed his Braden score as 10. Position was documented as left side from 12:00 AM until 4:00 AM, on right side from 4:00 AM until 8:00 AM and supine from 8:00 AM until 1:59 PM when OT did active range of motion exercises. Nursing documentation indicated, at 8:00 AM, "Skin Breakdown, Buttocks: Small open area, wound bed pink. Necrotic

tissue falling off, healthy tissue underneath."

9/26/07: His treatment flow sheet listed his Braden score as 14. Position documented as supine from 5:00 PM until 10:00 PM with supplemental repositioning at 8:00 PM. Nursing documentation at 8:00 Am and again at 8:00 PM is as follows, "Skin Breakdown, Buttocks: Dressing clean, dry intact.".

9/27/07: His treatment flow sheet listed his Braden score as 14. No nursing documentation on wound status. Position documented as left side from 12:00 AM until 8:00 AM.

Facility staff failed to provide the interventions recommended in the facility's Braden Scale policy prior to the CWOCN consult. On 25 days of the patient's 31 day hospital stay, his Braden Scale score was equal to or below 13. A CWOCN consultation was not initiated and an appropriate pressure reducing support surface was not provided according to the Braden Scale policy. CWOCN consultation was not done until the patient's 25th hospital day and after a decubitus had developed on his buttocks.

An appropriate pressure reducing surface, in the form of an overlay mattress, was documented on the Treatment Flow sheet of the EMR as being initiated on 9/1/07, off on 9/3/07 and reinitiated 9/14/07. There was no documentation that the overlay mattress was in place on 9/4 - 91/13/07 or on 9/23/07, 9/24/07 or 9/25/07.

Patient #46 was an 87 year old female who was admitted on 8/11/07 with the diagnosis of left hip fracture. This was treated surgically on 8/12/07 and the patient was discharged on 8/20/07. Her medical record did not include documentation that she was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the "WOUND and PRESSURE< ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, her EMR under "ACTIVITY Position" did not document evidence that the patient had been repositioned every 2 hours or was provided supplemental turning with small shifts in position during

the following dates and times: 8/11/07: Her treatment flow sheet listed her Braden score as 15. Position was documented as supine from 8:00 PM on 8/11 until 4:00 AM on 8/12. 8/12/07: Her treatment flow sheet listed her Braden score as 12. 8/13/07: Her treatment flow sheet listed her Braden score as 11. Position documented as supine from 12:00 AM until 10:00 AM and again supine from 12:00 PM until 4:00 PM. 8/14/07: Her treatment flow sheet listed her Braden score as 13. CWOCN consult at 11:30 AM notes, "request to see patient for low Braden score - 14 patient turned has purple are along coccyx and along gluteal fold apparently for crease in linen - will place patient on 1st step mattress and write to limit linen on bed to driflo pad and turn patient every two hours. Xenaderm to area on buttocks BID". Position documented as right side from 8:00 PM until 12:00 AM. 8/15/07: Her treatment flow sheet listed her Braden score as 16. Position was documented as supine from 4:00 AM until 12:00 PM with supplemental repositioning (not turning) at 8:00 AM. Position documented as right side from 2:00 PM until 8:00 PM. 8/16/07: Her treatment flow sheet listed her Braden scores as 12 and 12. Her treatment flow sheet indicated she was a two person assist to turn. Position was documented as supine from 2:00 AM until 2:00 PM with supplemental repositioning (not turning) at 7:00 AM. Position documented as supine from 4:00 PM until 10:00 PM with supplemental repositioning (not turning) at 6:00 PM. Continued documentation of position as right side from 10:00 PM on 8/16 until 4:00 AM on 8/17 with supplemental repositioning (not turning) at 2:00 AM. A CWOCN note stated, "redden areas remain unchanged on bottom...will provide barrier for patient".

8/17/07: Her treatment flow sheet listed her Braden score as 17. Additionally, the treatment flow sheet indicated her turning

required 2 person maximum assistance. Position was documented as supine from 8:00 AM until 10:00 PM with supplemental repositioning (not turning) at 12:00 PM and 4:00 PM. Nursing notes documented, "Reddened Skin, Sacral: small approx blister appearing lesion at the top of the gluteal fold; slight redness .5x1 cm L gluteal area".

8/18/07: Her treatment flow sheet listed her Braden score as 15. Position was documented as supine from 12:00 AM until 4:00 AM and again from 6:00 AM until 12:00 AM on 8/19 with supplemental repositioning (not turning) at 8:00 AM, 8:30 AM, 9:15 AM, 10:00 AM, 2:00 PM and 6:00 PM. Nursing notes documented at 12:00 AM, "Reddened Skin, Sacral: No dressing, area reddish purplish in color." Documentation also included, at 8:00 AM, "Reddened Skin, Sacral: No Dressing".

8/19/07: Her treatment flow sheet listed her Braden score as 14. Position was documented as right side from 12:00 AM until 8:00 AM. Position documented as supine from 8:00 AM until 12:00 AM on 8/20 with supplemental repositioning (not turning) at 10:00 AM, 12:00 PM, 4:00 PM, 6:00 PM and 8:00 PM. Nursing documentation at 12:00 AM states, "Reddened Skin, Sacral: No dressing small blister top of gluteal folds, L side blister, open to air with no s/s of infection topical applied blister appears to be healing". Further documentation at 8:00 PM states, "Reddened Skin, Sacral: No dressing".

8/20/07: Her treatment flow sheet listed her Braden score as 18. Position was documented as supine from 4:00 AM until 11:00 AM with supplemental repositioning (not turning) at 6:00 AM, 8:29 AM and 10:00 AM.

Facility staff failed to initiate the interventions recommended in the facility's BRADEN SCALE policy on 8/12/07 and 8/13/07. The policy stated that a score of 10-12 required, "1. Supplement turning with small shifts in position. 2. Provide appropriate pressure reducing support surface. 3. Dietary consult 4. CWOCN Consult for score equal to or less than 13."



January 7, 2008

Sylvia Creswell Idaho Department of Health and Welfare 3232 Elder Street P.O. Box 83720 Boise, Idaho 83720-0036

JAN 14 2008

FACILITY STANDARDS

Dear Ms. Creswell:

Attached please find Saint Alphonsus Regional Medical Center's plan of correction which is intended to address and rectify state licensure deficiencies cited during a survey concluded on November 20, 2007.

Since the deficiencies cited are substantially similar to those on the Statement of Deficiencies/Plan of Correction (CMS-2567) and we have already completed our Allegation of Compliance on that form, please reference those responses as specified in the attached form.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. The hospital takes the issues raised during the survey very seriously and have worked diligently to address each one.

We appreciate your thoughtful consideration of this plan of correction. Please contact Aline Lee, RN, Director of Patient Safety and Regulatory Compliance at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Andra B. Poerre

Sandra B. Bruce

President and CEO

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		130007		B. WING_		11/2	0/2007
NAME OF P	ROVIDER OR SUPPLIER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	STREET ADS	DRESS, CITY,	STATE, ZIP CODE	1172	0,200,
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
B 000	16.03.14 Initial Cor	nments		B 000			
	recertification and		on survey				
	Rae Jean McPhillip Patricia O'Hara, RN						
	Acronyms used in t	the survey report inc	lude:				
	Nurse DNS= Director of N ED = Emergency D EMR = Electronic N EMTEK = Hospital' System	d Wound-Ostomy-Co Iursing Department	entation				
	ICU = Intensive Ca Nsg = Nursing	re Unit				REC	EIVED
	PI = Program Impro	ovement				JAN	1 4 2008
	PT = Physical Ther Pt = Patient RN = Registered N SARMC = ST Alpho Center TIA = Transient isc UE = Upper Extrem	urse onsus Regional Med hemic attack	lical			FACILITY	STANDARD:
BB124	16.03.14.200.10 Q	•	N. Control	BB124			and a second
_ , ,	10. Quality Assurar and medical staff, t	nce. Through adminishe governing body san effective, hospita	hall		Please see response t A267 on CMS form 2567 on 12/27/2007.		

Bureau of Facility Standards

\*LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Danielra 181

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING		(X3) DATE S COMPLE	
		130007				11/2	0/2007
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provision of ca document app deficiencies fo hospital must or remedial action.  This Rule is no Based on revision improvement of was determined the hospital-widocumented a address deficient Prevalence studocument the track and analyadequately assoperations, and prevention and findings included.  The CWOC CWOCNs had at the following 8/07: 22 patient patients, 19 we acquired pressions.  9/07: 17 patient patients, 6 were acquired pressions.  10/07: 31 patients, 28 acquired pressions.  The hospital's	ropriund documents we ure ure we ure	program to evaluate to The hospital must tak iate remedial action to through the program ament the outcome of 0-14-88)  The tas evidenced by: If clinical records, qualified as a summents, and staff interior facility failed to ensignality assurance program. The hospital come of the remedial actiones found through their program. The hospital come of the remedial actiones of the hospital's services occesses of care related to the pressure ulcers.  The pressure ulcers activity sheets document patients with pressure ulcers.  The pressure ulcers activity pressure ulcers activity sheets document patients with pressure ulcers.  The pressure ulcers activity pressure ulcers activity sheets document patients with pressure ulcers.  The pressure ulcers activity pressure ulcers are identified as having hos ulcers.	e and o address. The other is the litty views, it ure that gram ins to reaction or early to es, ed to the The inented the ure ulcers. Of the 22 ospital of the 17 opital of the graphospital of the graphospital of Safety	BB124			

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	Pressure Ulcer Indicator" section that the hospital was "Improving definitions and data collection tools and processes for quarterly prevalence study. Defining standards of nursing assessment and pressure ulcer prevention interventions [sic]."  The facility's quality improvement document was a "Pressure Ulcer Prevalence Report" dated 8/21/07. The report was a facility wide screening that documented whether or not the patients had a pressure ulcer. The report consisted of a grid. Each column of the grid was labeled with patient information (i.e. room number, name, age, sex, admit date, etc.) and information related to pressure ulcers (i.e. Braden score, types of pressure ulcers (i.e. Braden score, types of ulcers, etc.). Each row of the grid represented a separate patient. When asked about the report on 11/16/07 at 9:43 AM, a CWOCN stated the report was completed one day each quarter, by completing a visual check of the patient and entering data on the grid which reflected each						
	documented there who had pressure the "Prevalence Rehad developed hos which included but following:  a. The row for Patie "Prevalence Report The first 6 columns	/07 "Prevalence Rep were no less than 9 pulcers. Of those 9 pa eport" documented 6 spital acquired presso were not limited to the ent #24 on the 8/21/0 t" stated the following s documented his roc RN, age, sex, and add	patients atients, patients are ulcers, ae				

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The 7th column stated "Assessment Prior to

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BB124	The 8th column stawas placed in the basessment." The The 10th column state how stated "Yes." The 11th column state how stated "Yes." "No Applicable." A che "No Evidence" box The 12th column state Prevention in Use" columns labeled "Perevention in Use" columns labeled "Nutritional The 13th column state was subdivided into Hospital Acquired," was placed in the "Acquired" column.  The 14th column state has been stage and we labeled "Stage" and we labeled "Stage I," "Stag	ras placed in the box ated "Braden Score." fox.  ated "Time Since Last box stated ">12 - 2  ated "Pt [patient] at les."  ated "Pressure Ulce as subdivided into 3 of Evidence" and "Not ck mark was placed and was subdivided Pressure Reducing Sutritional Support," anark was placed in the subdivided of the sure Reducing Sutritional Support," anark was placed in the sox and was placed in the sure resure reducing Sutritional Support," anark was placed in the sox and was placed in the support of the sure reducing Support," anark was placed in the sox and was placed in the support of the sure reducing Support," anark was placed in the sox and was subdivided the sure reducing Support, and support of the sure reducing Support of the support of the sure reducing Support of the	A "17"  t 24 Hours." Risk."  r columns in the ure Ulcer into 4 urface," nd ne column eers" and "Total," " " A "1" ne "Unit eers at columns "Stage	BB124			
		tated "Ulcer Location)." The word "buttoo					

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	and was subdivided	tated "Patient on 02 d into 2 columns labe kmark was placed in umn.	eled "Yes"				
	The 17th column stated "Ear Protectors or Mask" and was subdivided into 3 columns labeled "Yes," "No," and "NA." A checkmark was placed in the box under the "NA" column.  The 18th column stated "Reason Patient Not Assessed" and was subdivided into 4 columns labeled "Not Available," "Patient Discharged," "Patient Refused," and "Contraindicated." The boxes were left blank for Patient #24.						
				ALEJOHO MANARAM PARAMANANANANANANANANANANANANANANANANANAN			
	developed a unit ac on his buttocks. Ho Evidence" of "Press	revalence Report"  It #24 was at risk and  cquired, Stage II presoneever, there was "Neure Ulcer Prevention  and beyond nutritional	ssure ulcer lo n"	Contract visits.			
	Patient #24's nursir "Reddened SkinI blanches, barrier or [patient] to turn to he the documentation 11 days prior to the information related in his nursing notes 8/14/07, 8/15/07, and documented on 8/2	tegumentary/Skin" sing notes documente. Buttocksskin is recream applied, instructions side as much as provided was dated 8/9/07 at a "Prevalence Report to the area was documented at a dated 8/12/07, 8/13 and 8/21/07. His record at 3:30 PM and a gestion of the 8/21	d I, cted pt cossible." t 8:00 AM, :." Similar umented b/07, ord also air bed				
	completed one day	sure Ulcer Prevalenc each quarter, was n Patient #24 receive	ot				

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BB124	and appropriate preskin integrity. The seskin integrity indicators (i.e., the Patient #24's care of pressitioning, imples the hospital's wound and other such ope performance that has improved facility systems of pressure ulce.  b. The 8/21/07 "Preform for Patient #25. Report" documented had developed a hoppessure ulcer on hodocumented there we pressure ulcer on hodocumented there we seed.  However, Patient #28/9/07 at 8:00 AM of a "1x2 cm purple probuttocks and a "1x4 right posterior upper documented that a on 8/9/07 at 11:00 A Similar information on Patient #25's this documented in his resultance in his resultance in the set of t	eventative care related study did not docume data to identify specimeview and assessmit ecord for compliance mentation and adhered and Braden scale prational aspects of ad the potential to lestems for the preventions. In summary, the "Field Patient #25 was at pospital acquired Unstais head. The report was "No Evidence" of evention" measures a focumented he had of the same sore of thigh. The notes rotation mattress was resident acquires was a focumented he had of the same sore of thigh. The notes rotation mattress was review and according to the same sore of the same sore of the same sore of thigh. The notes rotation mattress was review and according to the same sore of the same	ent patient ific quality ent of e of rence to policies ad to tion and  uded a Prevalence t risk and tageable of being  ated developed left re" on his as initiated  ure areas 8/10/07, s on e had of his purple int] using	BB124	DEFICIENCY)		
	the pressure areas	on his thigh, buttock ited in his nursing no	s, and				

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 130007 11/20/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1055 NORTH CURTIS ROAD ST ALPHONSUS REGIONAL MEDICAL CENTEL **BOISE, ID 83706** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) BB124 Continued From page 6 BB124 8/14/07, 8/15/07, 8/16/07, and 8/17/07, The facility's "Pressure Ulcer Prevalence Report." completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospital's performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to the review and assessment of the patient's care record for compliance of repositioning, the implementation and adherence of the hospital's wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). c. Patient #33's 8/11/07 nursing assessment stated "Skin Breakdown ... Bottom ... Protective Ointment Applied." Similar information regarding the area was documented daily in his nursing assessments dated from 8/12/07 to 8/21/07. However, the 8/21/07 "Prevalence Report" included a row for Patient #33 but information related to his pressure ulcers was not included on the grid. Column 18 stated "Reason Patient Not Assessed" and an "x" was placed in the sub-column for "Contraindicated." When asked on 11/9/07 at 2:30 PM, why Patient #33 was considered "Contraindicated" an employee who worked in the PI department stated they did not know why he was contraindicated. The facility's "Pressure Ulcer Prevalence Report." completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospital's performance (i.e., specific day to day data to identify patient specific quality

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indicators such as but not limited to; the review

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and assessment of the compliance of repositi and adherence of the Braden scale policies, efficacy of the interver aspects of performance lead to improved facility prevention and care of the Braden scale policies, efficacy of the interver aspects of performance lead to improved facility prevention and care of the Braden scale policies, efficacy of the interver aspects of performance lead to improved facility prevention and care of the Braden scale present developed a hospital acquired present and that there was "Not Ulcer Prevention" measummary documentate "Prevalence Study" do hospital acquired present however, the summary documentation of the area. The summary in consistent with the "Prevalence Study" do hospital acquired present with the "Prevalence Study" do developed "Skin Breat open area 1inX1/4 in Note of the area of the pressure area on 8/20/07, and 8/21/07.  The facility's "Pressure completed one day easufficient information reasess the hospital's pressure as the hospital's pressure as the summary of the indicators such as but and assessment of the analyses.	e patients care recioning, the implem hospitals wound a performation related to the positive systems for the off pressure ulcers). Alence Report" inclin summary, the "Patient #23 was at poital and a unit acquerort documented and a Stage II pressore being used attended to the systems for the systems of "Prasures being used attended to the systems of	nentation and and and and and and and aperational atential to a prevalence at risk and quired a she had soure ulcer ressure at Further, le 1 spine.  The spine and a small and	BB124			

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DD 124	compliance of repositioning, the implementation and adherence of the hospitals wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers).  On 11/9/07 at 2:30 PM, a hospital employee who worked in the PI department stated the hospital did retain a day to day cumulative data base of patients that developed pressure ulcers. She confirmed the PI department did not have specific data of patients that included quality indicators that lead to the development of pressure ulcers. She said the PI department did not have a data			BB124			
	operations aspects have been used to and could have lead development of prehospital's PI depart plan based on cum of hospital acquired.  The Prevalence strevidence that the higher and processe study" or had defin assessment and printerventions") and development of a vof hospital acquired Prevalence study of specific day to day quality indicators (i	sospital services and of performance that assess the processed to the reduction of essure ulcers. She standards of persone ulcers. She standards of pressure ulcers.  In the study and Safe as a standards of nursessure ulcer prevalled "standards of nursessure ulcer prevent the study was not us written plan to reduce the pressure ulcers. Fulled not document pational data to identify patiente. In the compliance ecord for compliance	es of care the aid the written e the rate  cumented their ety Plan," collection ence sing ion eed in a the rate urther, the ent nt specific sment of				

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repositioning, implementation and adherence to

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BB124	and other such oper performance that development of the development of the The facility failed to quality improveme information necess hospital's services processes of care integrity.  2. Patient #33 was 8/11/07 and was dincident report, dar on 8/22/07, the "P" skin breakdown or discoloration, and coccyx on 8/22, sk applied and pt. [pa Wound consult ordonger intact and 1 I skin breakdown pevaluate. Skin prow/saran wrap to promove the patient haulcer, stated she direport.  On 11/8/07 at 9:30 incident reports are to investigate and department to analyze of the context of	and and Braden scale erational aspects of could have lead to the pressure ulcers).  To ensure the pressure in tystem included start to adequately as perations, and the related to patients' skips admitted to the hospischarged on 9/28/07 ted 8/23/07, document [patient] with 3/4 in X in L [left] coccyx area, several blisters on R in protectant [sic] creation of the present. Wound nurs of the present in the first given to the unit manable developed the present on the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on to the lyze the information and the passed on the passed on the lyze the information and the passed on the lyze the life the present the life the passed on the lyze the life the present the life the present the lyze the life the present the lyze the life the lyze	e ulcer ufficient sess the kin  pital on An nted that Y in oval purple [right] am sides. rs no und stage e in to aced  report 1/8/07 at ager at the sure incident  that it manager e Pl and	BB124		,,	
		g issues. He said tha					

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BB124	Continued From page 10			BB124			
	who worked in the were unaware of the confirmed the report hospital's process frequency of hospital and the facility failed to information was in	PM, 2 hospital emp PI department state ne incident report and ort was not used to a of patient care to rec tal acquired pressure to ensure all pertinent vestigated and analy d safeguard against	d they d ssess the duce the e ulcers. t incident zed in an				
BB173	310. NURSING SE There shall be an owith a plan that del and duties of each and a functional st planning and coop shall be in the nurs policy manuals. Jo available and in us responsibilities, fur	organized nursing de lineates authority, re- category of nursing ructure for cooperati eration. An organizati sing service office and b descriptions shall li- te which delineate actions or duties, and ach category of nurs	epartment sponsibility personnel, ve tional chart d in all oe	BB173	Please see response A395 on CMS form 256 on 12/27/2007.		
	service shall be un qualified registered experience comme	sing Services. The n der the overall direct d nurse with education ensurate with size an dospital whose duties	tion of a on and id				
		ordinate, and evaluatend staff; and (10-14-					
		le for development a policies and procedu					

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BB173	Continued From pa	age 11		BB173			-		
	they relate to care	of patients; and (10-	14-88)						
	c. To select, promote, and terminate nursing staff; and (10-14-88)								
		d. To establish a procedure to insure staff licenses are valid and current. (10-14-88)							
	Based on review o review, and staff in Director of Nursing nursing staff had in and procedures as standards of nursing (#s 23, 24, 25, 33, records were revie patients' had developressure ulcers. Treceiving adequate	This Rule is not met as evidenced by: Based on review of hospital policies, record review, and staff interviews, it was determined the Director of Nursing Services failed to ensure that nursing staff had implemented hospitals policies and procedures as they relate to the accepted standards of nursing practices for 8 of 18 patients (#s 23, 24, 25, 33, 46, 56, 57 and 59) whose records were reviewed and documented the patients' had developed hospital acquired pressure ulcers. This resulted in patients not receiving adequate care in the prevention and treatment of pressure ulcers. The findings include:							
	ULCER-ASSESSIN IRRIGATION AND revised in 5/06, sta Treatment for Pres	1. The hospital's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy, revised in 5/06, stated in the "Definition of and Treatment for Pressure Ulcers" section of the policy stated the following:							
	persistent redness whereas in darker appear with persis Suggested care ar pressure ulcers wa	er appears as defined in light pigmented sk skin tones, the ulcer tent red, blue, or purp nd treatment of stage as to use moisturizing tent to affected areas	kin, may ble hues." 1 creams						
		hickness skin loss inv , or both. The ulcer is							

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BB173	blister, or shallow of painful, and pink-resuperficial yellow streatment for stage cleanse with normal wound edges, appeday, cover the wound edges, appeday, cover the wound-adherent dressevery 24 - 48 hours. Stage III - "Full thick damage to, or nece that may extend do underlying fascia. a deep crater with adjacent tissue." It stage 3 pressure unormal saline, use edges, loosely pack wound gel or saline every 24 - 48 hours. Stage IV - "Full thick destruction, tissue muscle, bone, or stendon or joint cap treatment for stage cleanse with normal wound edges, loose and wound gel or stage during the nerves of the present, a pressure staged until the nerver purple or bruised as the superficient staged until the nerver purple or bruised as the superficient staged until the nerver purple or bruised as the superficient staged until the nerver purple or bruised as the superficient staged until the nerver purple or bruised as the superficient staged until the nerver purple or bruised as the superficient staged until the nerver purple or bruised as the superficient stages.	sents clinically as an craterIt is shallow, red in color and may helough" The care all 2 pressure ulcers in all saline, use skin prely protective ointment and with a foam or sing and change the s.  ckness skin loss involved in the ulcer presents or subcutaneous own to, but not through the ulcer presents or without undermining the care and treatment allowers included: clean skin prep around work the wound with gaue and change the dress.  ckness skin loss with necrosis, or damage upporting structures as a 4 pressure ulcers in all saline, use skin presely pack the wound we saline and change the saline and	noist, lave and cluded: ep around twice a dressings ving s tissue gh, linically as and of extensive to (e.g., d cluded: ep around with gauze es curately red. Dark ninences,	BB173			

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BB173	The "Documentatic staff were to "Docucolor, character, excolor, character, extraining scale that wistaff to assess for admission and dail."  The "BRADEN SC policy revised in 9/"The Braden Scale Risk is a tool that a care providers to sideveloping pressu assessed for pressidaily." Some reconcileded the follow Low Risk Score 15 - Encourage patie - Address risk factor Moderate Risk Score 15 - Encourage patie - Address risk factor Moderate Risk Score 16 - Supplement turn One example was degree foam wedg - Provide approprisurface. Some example was degree foam wedg - Certified Wound consult.  High Risk Score 16 - Supplement turn - Provide approprisurface.	on" section of the politiment daily and print kudate [sic] of all would stated "The Braden Sill be used by [hospital pressure ulcer risk at ly."  ALE for Predicting Ul 06, and again in 11/0 e for predicting Pressulows nurses and otheore a patient's level re ulcers. Patients are sure ulcer risk at adminimended interventioning:  ii-18: Int to turn and shift pottors.  ore 13-14: Ing with small shifts into increase turning we or pillows, at pressure reducing amples included specialty padded boots. Ostomy-Continence	ne size, ands."  Scale is a all's name]  Icer Risk"  17, stated ure Sore ner health for realission and ns  position.  In position.	BB173					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130007			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SU COMPLE	JRVEY TED 0/2007
NAME OF D	ROVIDER OR SUPPLIER	100007	STREET AD	DRESS CITY S	STATE, ZIP CODE	11/20	J/2001
	IONSUS REGIONAL I	MEDICAL CENTE		RTH CURTIS			
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BB173	Continued From pa	ige 14		BB173			
	Severe Risk Score  1. Supplement turn position.  2. Provide approprisurface.  3. Certified Wound consult.  The frequency of paddressed in either PRESSURE ULCE CULTURE, IRRIGA or the "BRADEN Stake" policies. Whe positioning, staff state above policy and the hospital's best least every 2 hours.  On 11/5/07 at 1:5 manager, stated paevery 2 hours in the assistance with repthat all patients' poevery 2 hours in the self turn or needed.  On 11/5/07 at 2:0 the hospital, stated repositioned every need assistance with also stated that CV for all patients that	less then or equal to ning with small shifts riate pressure reducing. Ostomy-Continence atient positioning was the "WOUND and R-ASSESSMENT are ATION AND DEBRID CALE for Predicting len asked about paties ated the following:  40 AM, a CWOCN could procedure and stappractice to turn paties	in  Ing support  Nurse  In not  Ind CARE;  IEMENT"  Ulcer  Int  Int  Int  Int  Int  Int  Int  In				
	documented in the	atients' positioning w EMTEK.	as to be				

- On 11/5/07 at 2:16 PM, a second nurse, who

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130007			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SI COMPLE	TED
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NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
BB1 <b>7</b> 3	Continued From page 15 worked as unit manager, stated all patients were		opts were	BB173			
	to be repositioned of move or need assist nurse also stated of all patients that had ulcers prior to adminished patients' positionin EMTEK whether the assistance with turn of 11/5/07 at 2:3 the hospital stated, repositioned every or needed assistant of 11/5/07 at 3:3 stated all patients whours if they could assistance with repositioned every or needed assistant of 11/6/07 at 9:4 patients that were iscale score of 13 of were to be followed.	every 2 hours if they stance with reposition CWOCNs were considered developed or had prission. The nurse stang was documented in they could self turn or ining.  9 PM, a nurse who we all patients were to be 2 hours if they could not with repositioning on PM, the hospital's leavere to be repositioned not move or needed positioning.  3 AM, a CWOCN standard standard self-self-self-self-self-self-self-self-	could not hing. The ulted for ressure ted that in the needed worked at person not move.  ONS ed every 2 atted all Braden te ulcers stated				
	they were responsible for assessing each patient to identify the patient's individual special needs to help prevent the development or further development of pressure ulcers including obtaining appropriate pressure reducing support surfaces, wound treatment, and staff education.						
	the hospital stated every 2 hours or mostated they rotated right side, to their b She stated this was	46 AM, a nurse who that patients were to ore if needed. The n patients from lying o back, then to their lefts recorded in the "AC f the patient's EMTER	be turned urse n their side. TIVITY				

The facility failed to ensure patients were assisted

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER			(X2) MULTI A. BUILDIN B. WING _		(X3) DATE SI COMPLE	TED
		130007	_			11/2	0/2007
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ST ALPHONSUS REGIONAL MEDICAL CENTEI  1055 NORTH CURTIS ROAD BOISE, ID 83706  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD							
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY	JST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)			N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
BB173	to reposition every "WOUND and PRE ULCER-ASSESSM IRRIGATION AND "BRADEN SCALE policy were consist  * Patient #33 was a 8/11/07 and was d patient was a 66 ye to the hospital afte his home. The pat was 9 (severe risk: shifts in position, p reducing support s Wound-Ostomy-Co Patient #33's medi documentation tha interventions as ou policy based on his Additionally, the "A his EMTEK docum repositioned every supplemental turni during the following  - 8/11/07: right side 8/12/07. His nursii BreakdownBotto Applied."  - 8/12/07: left side supine from 10:00 from 6:00 PM to 12 documented suppl change in the angle had occurred at 8:0 8:00 PM. His nurs	2 hours and that the ESSURE MENT and CARE; CUDEBRIDEMENT" ar for Predicting Ulcer I tently implemented a admitted to the hospitischarged on 9/28/07 ar old male that was repended by the provide appropriate provided in the Braden and admitting score of SCTIVITY Position" seented that he had no 2 hours or provided no with small shifts in	JLTURE, and the Risk" as follows: stal on 7. The stal admitted consive in consive in consive in consider the scale of the	BB173			

treatment flow sheet listed his Braden score as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPLE	
	IDENTIFICATION NUMBER:  130007			A. BUILDING B. WING		44/00/000	
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BB173	- 8/13/07: left side His nursing assess BreakdownBotto skin breakdown no listed his Braden s  - 8/14/07: right side supine from 4:00 A side from 2:00 PM assessment stated BreakdownBotto flow sheet listed hi  - 8/15/07: right side The record docum repositioning (i.e., head of the bed, e and 10:00 AM. His "Skin Breakdown skin intact." His tre Braden score as 1  - 8/16/07: right side and supine from 6: His nursing assess BreakdownBotto treatment flow she 11.  - 8/17/07: supine 6: supine from 10:00 The record docum repositioning (i.e., head of the bed, ei	from 12 midnight to sment stated "Skin mButtocks are red ofted." His treatment acore as 9.  The from 12:00 AM to 4 AM to 2:00 PM and ofte 6:00 PM. His nured "Skin mReddened." His is Braden score as 1 and the from 4:00 AM to 12 ented supplemental change in the angle to.) had occurred at a sinursing assessment. Bottomedness [side eatment flow sheet life 10.  The from 12:00 AM to 8:00 PM to 4:00 AM ofte 100 PM to 4:00	dened, no flow sheet 4:00 AM, n his right sing treatment 1. 2:00 PM. of the 8:00 AM nt stated c] noted sted his 8:00 AM n 8/17/07. is score as and /18/07. of the 8:00 AM.	BB173			
	BreakdownBotto	g assessment stated mless reddenned [ pen areas noted."  H	sic] than				

nursing assessment stated "Skin

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130007			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED . 11/20/2007	
MANE OF E	ADOLADED OD CLIDDLIED	100001	STREET AD	DRESS CITY	STATE, ZIP CODE	11/2	3/2001
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BB173	Continued From pa	age 18		BB173			
	BreakdownBottomNo dressing. 6-in diameter of redness. Open bleeding area noted." His treatment flow sheet listed his Braden score as 17 on 8/17/07 and as 11 on 8/18/07.  The facility failed to ensure Patient #33 was appropriately reposition every 2 hours, that the Braden scale policy interventions were implemented given his continued low scores						
	(supplement turning with small shifts in position, provide appropriate pressure reducing support surface, Certified Wound-Ostomy-Continence						
	occurred for his op- with normal saline, edges, apply protect cover the wound with dressing and chang hours) in accordant PRESSURE ULCE CULTURE, IRRIGA policy.	rse consult) and that appropriate wound care curred for his open pressure wound (cleanse h normal saline, use skin prep around wound ges, apply protective ointment twice a day, wer the wound with a foam or non-adherent essing and change the dressings every 24 - 48 curs) in accordance with the "WOUND and ESSURE ULCER-ASSESSMENT and CARE; ULTURE, IRRIGATION AND DEBRIDEMENT"					
	Patient #33's medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the progression of his pressure ulcer. The "ACTIVITY Position" section of his EMR documented that he was not positioned appropriately during the following dates and times:						
	supine from 10:00 assessment stated BreakdownBottor R buttocks. Redde	e from 4:00 AM to 10: AM to 10:00 PM. His "Skin mNo dressing, oper ened around and on Let listed his Braden s	nursing n area on " His				

Bureau of Facility Standards

- 8/20/07: supine from 2:00 PM to 8:00 PM. His

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 130007 11/20/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1055 NORTH CURTIS ROAD ST ALPHONSUS REGIONAL MEDICAL CENTEL BOISE, ID 83706 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) BB173 | Continued From page 19 **BB173** nursing assessment stated "Skin Breakdown...Bottom...reddened, has two small areas that are open and occasionally bleeding. cleaned well, applied barrier cream." His treatment flow sheet listed his Braden scores as 11 and 9. - 8/21/07: His nursing assessment stated "Skin Breakdown...Bottom...reddened, coccyx, has small opening noted to right buttocks, cleaned well and applied barrier crm [cream]...' Additionally, a CWOCN consult, dated 8/21/07. stated "First step [mattress] obtained for comfort care." His treatment flow sheet listed his Braden score as 11 and 13. - 8/22/07: His nursing assessment stated "Skin Breakdown...Bottom...1in blister and purple discoloration. 3/4in oval stage 1 breakdown." Additionally, an 8/23/07 Incident Report documented that on 8/22/07, the "PT [patient] with ¾ in X ¼ in oval skin breakdown on L [left] coccyx area, purple discoloration, and several blisters on R [right] coccyx on 8/22, skin protectant [sic] cream applied and pt. [patient] repositioned on sides. Wound consult ordered. On 8/23 blisters no longer intact and 1in round and 1/4in round stage I skin breakdown present. Wound nurse in to evaluate. Skin protectant [sic] cream placed w/saran wrap to prevent rubbing off." A Braden score was not documented on his treatment flow sheet. - 8/23/07; left side from 2:00 AM to 8:00 AM. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 4:00 AM. His nursing assessment stated "(Skin

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Breakdown...Rectum...1.5cmx2cm...No dressing Partial thickness skin loss blistered excoriated

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN B. WING		(X3) DATE S COMPLE	ETED	
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BB173	1.5cmx2cm. Barried dressing Wound is blisters have opened drainedRectum Partial thickness sk 3cmx3cm.Barrier [stated in the skin breakdown home. Has skin breakdown home. Has skin breakdown home. Has skin breakdown home in the skin protective pastimes daily]. Left had rainage - probably on the floor at home area with betadine prevalon boots at a sheet listed his Bra.  The facility failed to appropriately repose appropriate wound pressure wound (cl skin prep around wointment twice a dafoam or non-adhered dressings every 24 the "WOUND and FULCER-ASSESSM IRRIGATION AND Additionally, a CWC 8/21/07 despite his the 8/23/07 score of wound since 8/18/00.  On 11/9/07 at 10:10 the CWOCN departing in the single s	er cream appliedBot excoriated inflamed and and acmx3cmNo dress in loss open blister sic] cream applied."  DCN consult, dated formed on 8/21 that the rift [related to] being eakdown of both buttone [sic] at home - not and red wound base te is being applied queel has black eschar related to how he will eak black eschar related to how he will times." His treatmeden score as 18.  The ensure Patient #33 itioned every 2 hours care occurred for his eanse with normal sacund edges, apply play, cover the wound went dressing and character and CARE; CUDEBRIDEMENT" po DCN was not contact low Braden scores (if 18) and having an out the patient's present was not consulted the patient w	Large sing  8/23/07, his patient of down at tocks r/t ow outer is seen. Id [four - dry - no as laying paint the wear ent flow  was sand that is open aline, use rotective with a nge the dance with  LTURE, licy. Ited until prior to open  offirmed alted by	BB173			

Bureau of Facility Standards

STATE FORM JX1N11 If continuation sheet 21 of 52

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130007			(X2) MULTIP A. BUILDING B. WING	-	(X3) DATE S COMPLI		
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	IONSUS REGIONAL I	MEDICAL CENTE		RTH CURTIS			
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BB1 <b>7</b> 3	Continued From particles and p	s further documented every 2 hours or pag with small shifts in N nurse consult and an areas on his button's section of his EMT e was not positioned g the following dates and barrier cream applicated the section of his EMT eSkin and barrier cream applicated the section of his experience of of h	d that he provided in position the cks. The TEK and 2:00 AM popen plied." His "Skin manged diplastic echanged tomaR tent flow ed the en and ing used. ttocks was ind plastic	BB1 <b>7</b> 3	CROSS-REFERENCED TO THE DEFICIENCY		DATE
	- 8/26/07: His nursi "Dressing moist rei summary report sta are very irritated fro slightly during clear	air mattress. His tress Braden score as 13 assessment state inforced" and the shifted, "The areas on hom the loose stools and ing of them" His to Braden score as 10	ed ft nis bottom and bleed creatment				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN			(X3) DATE SURVEY COMPLETED	
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BB173	Continued From page 22  On 11/7/07 at 1:53 PM, an RN, who was a unit			BB173				
	On 11/7/07 at 1:53 PM, an RN, who was a unit manager on the unit to which the patient was admitted, stated nursing attempted to reposition the patient but he always went back to lying on his back. She also stated the patient was incontinent of stool and urine and was often moist or wet.							
	On 11/5/07 at 2:16 PM, a second nurse, who worked as unit manager on the unit to which the patient was admitted, stated the patient was not able to lay on his sides because it affected his vital signs and his blood pressure would drop and this was why he was not repositioned.							
	- 8/27/07: supine from 6:00 AM to 2:00 PM. His record documented that his linens had been changed at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 10:10 AM. His nursing assessment stated "Skin BreakdownBottomreddened excortiated [sic] bottom and coccyx. Barrier paste and saran wrap appliedSkin BreakdownRectum3cmx3cmreddened and excoriated barrier paste and saran wrap appliedSkin							
	BreakdownRectum1.5cmx2cmreddened ans [sic] excoriated barier [sic] paste and saran wrap applied." His treatment flow sheet listed his Braden score as 11.  - 8/28/07: supine from 8:00 AM to 12:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 10:00 AM. His nursing assessment at 8:15 AM stated "Skin BreakdownBottomBarrier cream with saran wrap, all the wounds are in a butterfly shape all connected togetherinto [sic] one wound							

	ATEMENT OF DEFICIENCIES O PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130007			(X2) MULTI A. BUILDING B. WING		(X3) DATE S COMPLE	
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BB173	nowContusion/He Heel4CMX2CM). 10:00 PM stated "S with Stage II decub Saran Wrap dressi noted" Additiona 8/28/07 at 11:30 Al dark eschar over it on the soft tissue w protective paste an nursing and empas importance of turni was black - soft ap blister - will continu prevelon boots" his Braden score a  On 11/9/07 at 10:1 the above docume hospital's best prace every 2 hours. She patient's Braden sc staff, per policy, sh with small shifts in  The facility failed to appropriately repos was no documente turning with small s ongoing progressic Additionally, despit the "importance of Position" section of document he was in during the following	ematomaR [right]" His nursing assessin BreakdownBobitus ulcer on sacraling inatct [sic]. No only, a CWOCN consider, stated "coccyx responsive with treated plastic wrap spokesized [sic] with nursing - right heel plantate pears to be resolving the with betadine to an His treatment flow slassing and 15.  O AM, a CWOCN contation and stated it betice to turn patients also confirmed that cale was 9 or less, the ould be supplementated by the patient's position of his pressure ulce the CWOCN's emiturning" the "ACTIVI fins EMTEK continuant repositioned every events and the positioned every expensioned events and the continuant repositioned events are set the continuant repositioned events and the continuant repositioned events are set the continuant reposition and repositioned events are set the continuant reposition and reposition are set the continuant reposition are set the continuant reposition and	ttomPt region. ozing uit, dated mains with I around tment of with ig ir posterior g blood rea and reet listed  onfirmed was the at least t if a at nursing ong turning the the cemental pite the cers. ohasis on TY ed to ry 2 hours	BB173			

then supine until 10:00 PM. His record also

documented he had a pad change at 2:00 PM. His nursing assessment at 12:41 AM stated "Skin

STATEMENT OF CORRECTION   (IV)   PROMOBERGUPPLEMOLIA   130007								
MAKE OF PROVIDER OR SUPPLIER  STALPHONSUS REGIONAL MEDICAL CENTEI    SUMMARY STATEMENT OF DEFICIENCIES   1055 NORTH CURTIS ROAD BOISE, ID 83706	AND PLAN OF CORRECTION IDENTIFICAT							
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STAPHONSUS REGIONAL MEDICAL CENTED   BOISE, ID 83706	NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
### REGULATORY OR LSC IDENTIFYING INFORMATION)  BB173  Continued From page 24  BreakdownBottomointment applied, stage 2-3 ulcer bilaterally" His nursing assessment at 3:30 PM stated "Skin BreakdownBottomreddened to bilateral buttocks, left buttocks has much larger area with redness to outside and some blackness to center of wound, very scanty amount of bleeding occasionally. Repositioning frequently" His treatment flow sheet listed his Braden score as 15.  - 8/30/07: His record also documented he had received a back rub at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 9:45 AM. His nursing assessment stated "Skin Breakdown BottomArea showing signs of healing. No s/s of infection noted. Area cleansed with peri-wipe, barrier cream applied and covered with plastic wrapContusion/HematomaR [right] heel4CMX2CMSkin remains intact" His treatment flow sheet listed his Braden score as 12.  - 8/31/07: left side from 6:00 AM to 10:00 AM, on his right side again from 10:00 PM until 4:00 AM on 9/1/07. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 12:00 PM and that he received a backrub, barrier cream and his linen was changed at 2:00 AM. Additionally, is convened to the second and covered with sinen was changed at 2:00 AM. Additionally, is convened as 2:00 AM. Additionally, a CWOCN consult, dated	ST ALPH	IONSUS REGIONAL	MEDICAL CENTE			ROAD		
Breakdown Bottomointment applied, stage 2-3 ulcer bilaterally" His nursing assessment at 3:30 PM stated "Skin Breakdown Bottomreddened to bilateral buttocks, left buttocks has much larger area with redness to outside and some blackness to center of wound, very scanty amount of bleeding occasionally. Repositioning frequently" His treatment flow sheet listed his Braden score as 15.  - 8/30/07: His record also documented he had received a back rub at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 9:45 AM. His nursing assessment stated "Skin Breakdown BottornArea showing signs of healing. No s/s of infection noted. Area cleansed with peri-wipe, barrier cream applied and covered with plastic wrapContusion/HematomaR [right] heel4CMX2OMSkin remains intact" His treatment flow sheet listed his Braden score as 12.  - 8/31/07: left side from 6:00 AM to 10:00 AM, on his right side again from 10:00 PM until 4:00 AM on 9/1/07. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 12:00 PM, and that he received a backrub, barrier cream and his linen was changed at 2:00 AM. Additionally, a CWOCN consult, dated	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE
8/31/07 at 3:30 PM, stated "area of dark eschar is getting smaller - red wound visible around perimeter of wound will continue with current treatment plan of skin protective paste and saran wrap" His treatment flow sheet listed his Braden score as 15.	BB173	BreakdownBotto ulcer bilaterally" 3:30 PM stated "S BreakdownBotto buttocks, left butto redness to outside of wound, very sea occasionally. Rep treatment flow she 15.  - 8/30/07: His received a back ruphysical Therapist of the bed at 9:45 stated "Skin Break signs of healing. It cleansed with periand covered with pwrapContusion/heel4CMX2CM treatment flow she 12.  - 8/31/07: left side his right side agair on 9/1/07. His received a back ruphysical Therapist of the bed, eand 12:00 PM and barrier cream and AM. Additionally, 8/31/07 at 3:30 PM getting smaller - reperimeter of wountreatment plan of swrap" His treatment plan of swrap" His treatment with the stream and the stream and swrap"	imointment applied, His nursing assessmely kin Imreddened to bilate locks has much larger and some blackness anty amount of bleeding ositioning frequently Let listed his Braden so location and the standard and the stan	eral area with a to center and area with a to center as "His core as he had at the edge essment a showing ed. Area applied "His core as "O AM, on I, and on 4:00 AM plemental of the 1:00 AM plement	BB173			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDINI B. WING		(X3) DATE S COMPLE	ETED	
		130007				11/2	20/2007
NAME OF F			STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST ALPH	IONSUS REGIONAL I	MEDICAL CENTE	1055 NOR BOISE, ID	RTH CURTIS 83706	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
BB173	wound care see tree his heel was floated treatment flow sheed documentation of his treatment flow sheed 14 and 16.  The facility failed to appropriately reposition in the records consists status and intervent "ACTIVITY Position documented he correspropriately during times:  - 9/2/07: right side if supine from 6:00 P documented supple change in the angle had occurred at 4:00 his bed pad was also nursing assessment notable for full thick pink granular tissue moist, without s/s of transparent dressing skin has 2x3 cm andrainage or dressing listed his Braden so - 9/3/07: His nursing "Bottomlarge decirity in the state of th	g assessment stated attment Flowsheet [statement Flowsheet [statement Flowsheet [statement Flowsheet] and not include his wounds until 9/12 at listed his Braden statement flowsheet Flows	wever, his wever, his wever, his wever, his wever, his word. Was sand that bund he EK cositioned and  O PM and record g (i.e., bed, etc.) and that PM. His ea is with Area is with Area is with CMintact Without flow sheet	BB173	DEFICIENCY		
	has eschar" His to Braden score as 14 - 9/4/07: right side f	eel4CMX2CMrt [i treatment flow sheet I and 19. from 8:00 AM to 4:00 I that the Physical Th	DPM. His				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	(XI) TROTIDEIOGITELLIOUN		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	130007		B. WING _		11/2	0/2007
NAME OF PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ST ALPHONSUS REGIONAL MEDICAL CENTEI 1055 NOI BOISE, IE			TH CURTIS 83706	ROAD		
PREFIX (EACH DEFICIENCY MUS	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
had Patient #33 sit at the PM. His nursing assess decubitis with brownish open on both cheeks, we saran wrap replaced" at 4:00 PM stated "But ulcerations on buttocks blackened areas noted followingR [right] heel remain off bed et boots pressure is on feet or he sheet listed his Braden - 9/5/07: left side from 6 record documented that had Patient #33 sit at the 11:54 AM and the Occu assisted Patient #33 to at 2:00 PM. His nursing "Bottom5cm in diame with superficial breakdon heel4CMX2CMblack treatment flow sheet list 13.  - 9/6/07: His nursing ass "BottomBarrier cream nurse. Black eschar ov breakdown area x1 and areaR [right] heel4Cdiam. Prevalon boot into sheet listed his Braden - 9/7/07: His nursing ass "BottomSacral area we slight bleeding around each with granulation. heel4CMX2CMNot of the CWOCN's notes, days as the property of the cwocN's notes, days are property of the cwocN's notes, days as the property of the prope	the edge of the bessment stated "Both tissue, reddened wound care done "His nursing assubttombilateral states discovered wound service discovered wound service simplace [sic] and heels" His treatment of the Physical The score as 13 and 6:00 AM to 6:00 Foot the Physical The supational Therapists of the best particular and combing assessment stated own peripherally ckened area intacts of the best particular and seed per wound the properties of the peripheral stated with area of eschalar and seed of the peripheral stated of the periph	els no ment flow 12.  PM. His erapist d at st had his hair ated lar area .R [right] t" His core as and care iameter] mater] 1/2 inch ment flow 12.  PM. Some and care iameter] mater ater ater ater ater ater ater ater	BB173			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130007		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED		
		100001	T STREET AC	DDESS CITY	STATE, ZIP CODE		0,2001
NAME OF P	PROVIDER OR SUPPLIER				·		
ST ALPH	IONSUS REGIONAL	MEDICAL CENTE	1055 NOF BOISE, ID	RTH CURTIS 83706	ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
BB173	Continued From pa	age 27		BB1 <b>7</b> 3			
	just moved to this t sheet listed his Bra	ructed on wound care unit" His treatment aden score as 17, 16	t flow , and 10.				
	"BottomPt has ve breakdown on butt	ng assessment stated ery large full thicknes tock. 2 areas on the he R. [right] Largest	ss L [left]				
	necrotic tissue in the granulation tissue s	he center with bleedi surrounding. Cleans	ng sed with				
	Other breakdown of [sic] still full thickness	applied polymen dres on the R [right] is sma ess decub with grant	aller butr				
	blister on the R [rig	b notinedR [right] .has darkpurple [sic] ght] heel, skin is intac ent flow sheet listed h	ct and				
	score as 12 and 10	).					
	record documented (i.e., change in the etc.) had occurred	om 6:00 PM to midnig d supplemental repo angle of the head of at 8:00 PM and 10:0	sitioning f the bed, 00 PM. His				
	BreakdownBottor	nt at 8:00 AM stated mDressing with sm	nall				
	polymen applied. I	ainage; changed and Patient has full-thick	ness				
	one on R [Right].	tocks; two areas on I The left buttock has I center and bleeding g	black				
		. The right is full-thic					
	tissueContusion/ Heel4cmx2cmk	'HematomaR [Righ blood blister to R [Rig	ght] heel."				
	stated "Reddened	rsing assessment at SkinNose[checke	ed]				
		ry, intact" His treat aden score as 11 and					

- 9/10/07: right side from 4:00 AM to 9:00 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130007		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMPLE	(X3) DATE SURVEY COMPLETED 11/20/2007		
			CTREET AD	DRESS CITY	STATE, ZIP CODE	11/2	0/2001
TO INIL OF THE OWNER OWNER OF THE OWNER OWN			RTH CURTIS				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE OATE	
BB173	head of the bed, et His nursing assess BreakdownBotton dressing present. reddened and oper [signs/symptoms] of SkinNoseSkin indry, and intact. No infection." A Brade treatment flow sheet 12/07. His record repositioning (i.e., of head of the bed, et on 9/11/07 and at 8 a bed bath) on 9/12 stated "Skin Breakdopen area to coccy noted to center of woundContusion. Heel4cmx2cmpsmall blister noted SkinNoseredde been open but is he sheet listed his Brade 12:08 PM. It is record also door Therapist had Patie bed at 12:08 PM. It is skin Breakdown barrier applied per ordersReddened Dressing clean, dry	ented supplemental change in the angle of c.) had occurred at 8 ment stated at 8:00 lmMinimal drainage Large eschar present skin surrounding it. of infectionRedden reddened. Dressing s/s [signs/symptoms en score was not listered.  from 12:00 PM to 12:00 documented supplemented supplemented in the angle of c.) had occurred at 28:00 AM and 10:00 Al 2007. His nursing asset of left heel Redden end, very small area ealing." His treatmented that the Phent #33 sit at the edgelis nursing assessmented supplemented that the Phent #33 sit at the edgelis nursing assessmented bottomno dressing	:00 AM. PM "Skin , no t with No s/s ed clean, s] of d on his  00 PM on emental of the :00 PM M (during sessment dened or [sic] or et that has nt flow 12. 00 PM. ysical e of the ent stated g, skin ed] nent flow	BB173			

- 9/13/07: left side from 12:00 AM to 4:00 AM,

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1055 NORTH CURTIS ROAD BOISE, ID 83706  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED			
ST ALPHONSUS REGIONAL MEDICAL CENTEI  1055 NORTH CURTIS ROAD BOISE, ID 83706  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)				070557.405	DEGG OFF	OT. TE 7/2 00 DE	11/2	0/2007
ST ALPHONSUS REGIONAL MEDICAL CENTEI BOISE, ID 83706  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF F	PROVIDER OR SUPPLIER				·		
(CAN) DEPOS DE CONTRE DE C	ST ALPH	IONSUS REGIONAL I	MEDICAL CENTE			ROAD		
	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
supine from 4:00 AM to 2:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 10:00 AM. His nursing assessment stated "Skin BreakdownBottomNo drsg. [dressing] area is red and has so [sic] eschar that is dry. Ointment appliedContusion/HematomaR [Right] Heel4cmx2cmPrevolen boots on. Small bilster to left heel. No s/s [signs/symptoms] of infectionReddened SkinNoseArea to bridge of nose is oozing and breakdown from BIPAP mask. Drsg (dressing) is present." His treatment flow sheet listed his Braden score as 12 and 13.  - 9/14/07: right side from 8:00 AM to 12:00 PM, and laying on his left side from 6:00 PM to 10:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 10:00 AM. His nursing assessment stated "Skin BreakdownBottomointment in placeContusion/HematomaR [Right] Heel4cmx2cmecchymotic purple 3cm diameter bilsterReddened SkinNoseWound is exconiated black with eschar on bridge of nose; no drainage" A Braden score was not listed on his treatment flow sheet.  -9/15/07: supine from 6:00 PM to 10:00 PM. His record documented he had received barrier cream and a bed pad change at 8:00 PM. His nursing assessment stated "Skin BreakdownBottomarea has slight bleeding spots on bottom. [sic] center, [sic] of wound is black and necrotice [sic]. Out side [sic] edges of wound appear to be pealing awayReddened SkinNoseReddened SkinNoseWeddened SkinNose and the slight page of wound appear to be pealing awayReddened SkinNoseReddened	BB173	supine from 4:00 A documented supple change in the angle had occurred at 8:0 nursing assessmer BreakdownBottor red and has so [sic appliedContusion Heel4cmx2cmF blister to left heel. infectionReddene of nose is oozing at mask. Drsg [dress flow sheet listed his - 9/14/07: right side and laying on his le PM. His record docrepositioning (i.e., chead of the bed, etcHis nursing assess BreakdownBottor placeContusion/Heel4cmx2cmediameter blisterR is excoriated black no drainage" A Bhis treatment flow sheet listed black and necrotice wound appear to be suppled to the supplementation of	M to 2:00 PM. His resemental repositioning of the head of the both AM and 10:00 AM and 10:00 AM and stated "Skin mNo drsg. [dressing] eschar that is dry. HematomaR [Right] Prevolen boots on. Stock [signs/symptoted SkinNoseArea and breakdown from Eding] is present." His is Braden score as 12 from 8:00 AM to 12: ft side from 6:00 PM cumented supplements and occurred at 1 ment stated "Skin mointment in HematomaR [Right] is chymotic purple 3c eddened SkinNose with eschar on bridgeraden score was not sheet.  In 6:00 PM to 10:00 In he had received ball and change at 8:00 PM and change at 8:00 P	g (i.e., led, etc.) His g] area is Ointment ht] mall ms] of to bridge BIPAP treatment and 13. 00 PM, to 10:00 htal of the 0:00 AM.	BB173			

Braden score as 14 and 9.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 130007			(X2) MULTIF A. BUILDING B. WING	-	(X3) DATE S COMPLE		
MAME OF D	DOMNED OR CHIRDHER	_100007	STREET AD	DRESS CITY S	TATE, ZIP CODE	11/2	UIZUU I
				RTH CURTIS			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
BB173	BreakdownBotto checks [sic] that a areas of bleed. [sic [sic] wounds is bla necroticContusion Heel4cmx2cm scabbed with large His treatment flow as 15.  -9/17/07: right side record documente (i.e., change in the etc.) had occurred 1:43 PM, the CWC care physician not madePatient is bwill need same cathis treatment flow as 15 and 13.  - 9/18/07: His nurs BreakdownBotto left buttock/coccyx sidesContusion/Heel4cmx2cm inch black circle, cosized black area SkinNoseScab His treatment flow as 15.  The facility failed to appropriately report Additionally, the we 9/11/07, was not as	sing assessment statumlarge area on bilare stage 3 ulcer with a climit of middle of right buttock and on/HematomaR [Right Reddened SkinNose wound at the bridge sheet listed his Brade from 4:00 AM to 2:0 d supplemental repose angle of the head of at 12:00 PM. On 9/20 CN documented, " yet in but referral was being turned and is on the statumBlack escar [sic] area, deep area open HematomaR [Right Right heel approx 1.5 losedleft heel has estage and sing assessment statumBlack escar [sic] area, deep area open HematomaR [Right Right heel approx 1.5 losedleft heel has estage and sing assessment statumBlack escar [sic] area, deep area open HematomaR [Right heel approx 1.5] losedleft heel has estage and sing assessment statumBlack escar [sic] area, deep area open HematomaR [Right heel approx 1.5] losedleft heel has estage area.	ateral some check ght] searea is of nose." en score 0 PM. His sitioning the bed, 17/07 at Wound sen air bed. asferred" en score ded "Skin noted on en on both of inchx1 eraser applied" en score was s. noted on until	BB173			

"ACTIVITY Position" documented he continued to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED			
		130007				11/2	0/2007
1				DRESS, CITY, :	STATE, ZIP CODE		
ST ALPHONSUS REGIONAL MEDICAL CENTER BOISE, ID				RTH CURTIS 83706	ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
BB173	not be repositioned  - 9/19/07: His nurs BreakdownBotto dry, intact. BreakdownBotto dry, intact. BreakdownBotto dry, intact. Breakdown necrotic tissue in centerContusion. Heel4cmx2cm area on heel. Prev SkinNosescab Bacitracin ointmen sheet listed his Bra  - 9/20/07: His nurs "contacted woun name] wound [sic] likely to debride wo rehab." His treatm Braden score as 1  -9/21/07: supine for record also docum bath and linen cha note stated "Nose is resolving. Cocc resolving, deeper v yellow slough. I co granular tissue is p acute infection. No confusion with who and suggested tha debridement. Patie if DC'd [discharged facility]. Same woo benefit from algina has some depth. I reccomendations [	d appropriately as folking assessment states m[checked dressin lown has quarter-sized/HematomaR [Righ blood blister present it valon boots on Redubed over. Dime-sized tapplied." His treatmeden score as 16 and ing assessment stated ing assessment stated in ursestated[phynot be coming to flood ound when transferrement flow sheet listed become at 10:15 AM. His is healing well and easyx ulcer with black eswith debridement and onservatively removed oresent. No odor or so officed [physician's nate was coming to debrit to patient could beneficent should continue at the could be cound care needed. Cound care needed. Cound care needed. Cound care needed. Cound care needed out these sic] and attached to the cound attached to the cound care attached to the cound care attached to the cound care attached to the cound attached to the cound care attached	ed "Skin g clean, ed area of t] in 4x2 cm dened d. hent flow 12. ed ysician's or and d to his PM. His ed a bed is CWOCN car [sic] base with d and new igns of me] of ide wound t from hir overlay are build e. It now the DC	BB173			
	[discharge] orders listed his Braden s	" His treatment flow core as 14.	w sheet				

NAME OF PROVIDER OR SUPPLIER  STALPHONSUS REGIONAL MEDICAL CENTEI  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  BB173  Continued From page 32  -9/22/07: left side from 12:00 AM to 8:00 AM and on his right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:15 PM. His nursing assessment stated  "Wound to coccyx debrided by Wound service. Wound base is covered greater than 50% with thick, yellow slough. Unknown if discharge will take place on Sun or Mon." His treatment flow sheet listed his Braden score as 15 and 14.		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION	(X3) DATE S		
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS REGIONAL MEDICAL CENTEI  (X4) ID PREFIX TAG  TAG  (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  BB173  Continued From page 32  -9/22/07: left side from 12:00 AM to 8:00 AM and on his right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:15 PM. His nursing assessment stated  "Wound base is covered greater than 50% with thick, yellow slough. Unknown if discharge will take place on Sun or Mon." His treatment flow sheet listed his Braden score as 15 and 14.	AND FLAN	OF CORRECTION	IDENTIFICATION N	MREK;	A. BUILDING			
ST ALPHONSUS REGIONAL MEDICAL CENTEI    1055 NORTH CURTIS ROAD B0/SE, ID 83706   10 8370					B. WING	11/2	/20/2007	
STALPHONSUS REGIONAL MEDICAL CENTER   BOISE, ID 83706	NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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-9/22/07: left side from 12:00 AM to 8:00 AM and on his right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:15 PM. His nursing assessment stated "Wound to coccyx debrided by Wound service. Wound base is covered greater than 50% with thick, yellow slough. Unknown if discharge will take place on Sun or Mon." His treatment flow sheet listed his Braden score as 15 and 14.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED B	Y FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
"Surgery I have examined Pt's [patient's] sacral decubitus ulcer. It seems as though another surgeon was initially consulted to evaluate this problem. Currently, my opinion is that the wound looks reasonably clean with granulation noted. I would not be interested in debriding the wound @ this time, as less aggressive measures are working." His treatment flow sheet listed his Braden score as 16.  - 9/24/07: His nursing assessment stated "Coccyx large red to pink open area with no s/s [signs/symptoms] of infection, signs of healing noted, dressing changed per ordersContusion/HematomaR [Right] Heel4cmx2cmNo c/o [complaints of] tenderness, heel in bootie and floatedReddened SkinNoseBrown scab noted on bridge of nose, no s/s [signs/symptoms] of infection or drainage notedPadding placed under BiPAP mask." A CWOCN note stated "Nose eschar continues with no redness - decreasing in size - dry. Right heel eschar is dry - no drainage - to be transferred today" His treatment flow sheet listed his Braden score as 13.	BB173	-9/22/07: left side for his right side for record documenter had Patient #33 sit 12:15 PM. His nur "Wound to coccyx Wound base is conthick, yellow sloughtake place on Sunsheet listed his Brates of the place of	from 12:00 AM to 8:00 M s:00 AM to 4:00 M s:00 AM to 4:00 M that the Physical Total that the edge of the bring assessment state debrided by Wound wered greater than 5 m. Unknown if dischor Mon." His treatmeden score as 15 and sian's progress note amined Pt's [patient's seems as though and ly consulted to evaluate and with granulation ested in debriding the gressive measures the them the seems as though and the seems as though and the seems are seems as the seems are seems are seems as the seems are seems are seems as the seems are seem	PM. His herapist bed at ated service. 0% with arge will hent flow d 14. stated 's] sacral nother pate this the wound @ sare ed his ed with no s/s healing ht] of] n scab symptoms] g placed stated ss - char is dry" His	BB173			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN B. WING		(X3) DATE S COMPL	ETED	
130007					11/2	20/2007	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
OT ALBUMNELIC DECIMINAL MEDICAL CENTEL		1055 NOR BOISE, ID	TH CURTIS 83706	ROAD			
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BB173	Continued From pa	ige 33		BB173			
	BreakdownBottor drainage noted at c red with evidence c	mDressing intact, we enter of wound, edgo of healing notedR (r His treatment flow s	es pink to right]				
	- 9/26/07: His nursing assessment stated "Skin BreakdownBottomDressing clean, dry, intact. Wound edges pink to red. Small amount of thick white drainage in center of wound. No s/s [signs/symptoms] of infectionR [right] heel4cmx2cmReddened SkinNoseNo dressing; small scab present, no s/s [signs/symptoms] of infection. Evidence of healing present. Bacitracin ointment applied." A Braden score was not recorded on his treatment flow sheet.						
	5	eakdownBottomN ne." His treatment flo core as 14.					
	- 9/28/07: Patient # Extended Care Fac	33 was discharged to cility.	o an				
	When asked about Patient #33's records, the CWOCN stated on 11/9/07 at 10:10 AM, the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer, per policy, until 8/21/07 and she confirmed the EMTEK documentation.						
	and timely care for facility's "WOUND a ULCER-ASSESSM IRRIGATION AND "BRADEN SCALE to policies were not in	t provided with approhis pressure wounds and PRESSURE IENT and CARE; CUDEBRIDEMENT" and for Predicting Ulcer Forlemented. Patient de documentation the	LTURE, d Risk" #33's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST ALPHONSUS REGIONAL MEDICAL CENTER BOI			1055 NOF BOISE, ID	RTH CURTIS 83706	ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE COME  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
BB173	consistently reposishifts in position are consistently reflect interventions. The ensure Patient #33 evaluated on an orwith accepted standhospital policy.  * Patient #25 was a 8/7/07 and was dispatient was a 74 yevalve replacement. His medical record that he was provide outlined in the "BR Ulcer Risk" policy a PRESSURE ULCE CULTURE, IRRIG, policy as follows:  - 8/7/07: His treatm Braden score as 2: surgery.  - 8/8/07: His treatm Braden score as 1:  - 8/9/07: The "ACT EMTEK documents been repositioned documented that he 8:00 AM and from record documented (i.e., change in the etc.) had occurred 12:00 PM and that initiated at 11:00 A	ition every 2 hours with his records did not a his wound status and Supervising RN failed it is some appropriate of the hospital admitted to the hospital and coronary artery it is and coronary artery it is and coronary artery it is and the "WOUND and the "WOUND and ER-ASSESSMENT are ATION AND DEBRID and the flow sheet listed it is and the surgery and the the surgery and the surger	d to ately dance ctice and tal on The an aortic cypass. mentation as edicting d CARE; EMENT" his 14 after his con of his e had EMTEK 00 AM to His sitioning the bed, M and was w sheet	BB173			
). Andrews	initiated at 11:00 A listed his Braden se	M. His treatment flow	v sheet lis nursing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVICE COMPLETE	
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ST ALPHONSUS REGIONAL MEDICAL CENTEI 1055 NORTH CURTIS ROAD BOISE, ID 83706	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
reddened skin on his left buttocks due to pressure. The notes documented at 8:00 AM, "1x2 cm purple pressure sore, skin intact, protective barrier cream applied." His nursing notes also documented he had a skin impairment of reddened skin on his right posterior upper thigh due to pressure. The notes documented at 8:00 AM, "No dressing, 1x4 purple pressure sore, skin intact, protective barrier cream applied." His nursing assessment at 6:25 PM stated "Pressure sores on back side, intact, change out bed to specialty one w/rotation feature"  - 8/10/07: His treatment flow sheet listed his Braden score as 10. His nursing notes at 8:00 AM stated "left buttocksSkin intact but reddened" and "upper thighSkin intact."  - 8/11/107: His treatment flow sheet listed his Braden score as 12. His 8:00 AM nursing notes stated "left buttocksSkin intact but reddened" and "upper thigh2 inch area of dark red skin, skin intact."  - 8/12/07: His treatment flow sheet listed his Braden score as 15. His 7:30 AM nursing notes documented "left buttocksApproximately the size of a pencil eraser, opened with slight bleeding noted" and "upper thighirregular oval shaped reddened pressure area noted. Skin intact. Approx ½ inch in length."  - 8/13/07: His treatment flow sheet listed his Braden score as 18. His 8:00 AM, nursing notes documented "left buttocksApproximately the size of a pencil eraser, opened with slight bleeding noted" and "upper thighirregular oval shaped reddened pressure area noted. Skin intact. Approx ½ inch in length."  - 8/13/07: His treatment flow sheet listed his Braden score as 18. His 8:00 AM, nursing notes documented "left buttocksarea is covered with barrier cream. Area is beginning to heal" and "upper thighno dressing, covered with barrier cream." Additionally, at 8:00 PM, his nursing notes documented heal a skin integrity impairment of skin breakdown on the back of his	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPLE				
		130007		8. WING 11/20/20					
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BB173	Continued From pa	age 36		BB173					
		stated "Area reddish p e of quarter, Pt [patie							
	Patient #25's record did not include documentation that staff covered the open wound on his left buttocks with a foam or non-adherent dressing every 24 to 48 hours per the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, there was no documented evidence that the CWOCN was consulted per the "BRADEN SCALE for Predicting Ulcer Risk" policy due to his low Braden scores (i.e., 13 or below as documented on 8/8, 8/10, and 8/11/07). His medical records further documented the following:  - 8/14/07: His treatment flow sheet listed his Braden score as 17. His 8:00 AM, nursing notes stated "left buttocksReddened and wound is open and appears to be in early stages of healingbarrier applied" and "upper thighReddened/purplish in color barrier applied. Skin appears to be intact." Additionally, the notes documented "back of headRemains reddish/purple in color. Skin is intact. Donut [sic] remains in place."								
							TO THE RESIDENCE OF THE PARTY O		
	- 8/15/07: His treatment flow sheet listed his Braden score as 17 and 19. His 8:00 AM nursing notes stated "left buttocksNo dressing, remains reddened, barrier applied" and "upper thighNo dressing." Additionally, his nursing notes documented "back of headRemains intact, purplish in color."								
	Braden score as 20	tment flow sheet listed 0. His 8:00 AM nursi sNo dressing, skin	ng notes						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN B. WING			(X3) DATE SURVEY COMPLETED				
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BB173	redness" and "upper surrounding skin red surrounding skin red Skin barrier ointme stated "back of heat scabbed over, no described over, no service developing ulcers, Patient #25' include documente was consulted. On CWOCN confirmed not consulted by no pressure ulcers.  Patient #25 was no and timely care for facility's "WOUND ULCER-ASSESSM IRRIGATION AND "BRADEN SCALE policies were not in Patient #25's Brade of pressure ulcers, did not include documentally reposition. Technological position. Technological position. Technological position. Technological position.	er thighNo dressing ed, wound yellow, no ent prn." Additionally, adNo dressing, would also also dressing, would also dressing. TIVITY Position" sective to documented Patient from 4:00 AM until a patient was reposition to present in the paradocumented he walked 280 feet at 4:00 Planot listed on his treat of nursing notes documented area approximating or symptoms] into the provided area approximating or symptoms and the CWOCN departuring staff about Patient and CARE; CU DEBRIDEMENT" and the provided with approximation of the predicting Ulcer For the predicting Ulcer For the predicting Ulcer For the provided with approximation that he we can be supervising RN for Predicting Ulcer For the provided with the weign every 2 hours with the Supervising RN for the Supervision	drainage. the notes and  tion of the ent #25 6:00 PM. oned tient's ted 140 M. A ment flow mented ely 3 cm fection."  sure d not CWOCN a tment was ient #25's  opriate b. The LTURE, d Risk" nse to velopment b's record as th small ailed to	BB1 <b>7</b> 3					
	ensure Patient #25	he Supervising RN fa 's care was appropria going basis in accord	ately						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE S COMPLI	ETED	
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BB173	with accepted stand hospital policy.  * Patient #24 was a 8/2/07 and was discipatient was a 80 yer of underlying coagule hepatitis. At the time Braden scale score supplement turning such as increased wedge or pillows, preducing support sumattresses or specific #24's medical record documentation that interventions as our policy based on his Additionally, his metallowing:  - 8/9/07: At 8:00 All section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his section of his nursing "Reddened Skin Explained Blanches, barrier or [patient] to turn to his s	dards of nursing practical dards of nursing practical dards of nursing practical dards of 8/23/07. The proof of 14 (Moderate Rister) with small shifts in particular of 14 (Moderate Rister) with small shifts in particular darks of 14 (Moderate Rister) with small shifts in particular darks of 14 (Moderate Rister) with small shifts in particular darks of 14 (Moderate Rister) with a 30 degrovide appropriate purface such as a specialty padded boots).	tal on The d a history coholic he had a sk Score, cosition gree foam ressure cialty Patient th scale 4. ented the d cted pt cossible." ry/Skin" d ry/Skin" d position nted ft side 10 PM the anges ted eep of	BB173			

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	IONSUS REGIONAL	MEDICAL CENTE		RTH CURTIS			
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BB173	- 8/14/07: At 8:00 I section of his nurs is reddedend [sic]. breakdown."  - 8/15/07: At 12:00 section of his nurs "Coccyx is red but on his sides so is 8:00 AM the notes red, dry and intact his sides."  - 8/21/07: At 11:18 section of his nurs 2 small areas of broare nurse aware. ordered." At 4:00 "Two small areas of applied and pt [pat Additionally, the 8/documented Patie developed a unit a on his buttocks. Hevidence" of "Pres measures being us according to the refurther stated at 3: per suggestion of the and a CWOCN no ointment was to be needed and the pareminded to turn e	provided buttocks area with sinage."  PM the "Integumentaring notes documente No s/s [signs/symptom AM the "Integumentaring notes documente intact. Pt [patient] with his back all the time documented "Coccy. Pt. [patient] refuses  AM the "Integumentaring notes documented and xenaders and xenaders per provided and xenaders per provided and xenaders are the side of t	ry/Skin" d "coccyx oms] of ary/Skin" d If not lie ie." At z [sic] is to lie on ary/Skin" d "Pt has Wound mented derm de." eport" d had sure ulcer lo n" I support sessment s initiated, se study kenaderm I as ted or ary/Skin"	BB173			
		ing notes documented] Right bottock [sic], a					Ì

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1055 NORTH CURTIS ROAD BOISE, ID 83706  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION	— COMPL	(X3) DATE SURVEY COMPLETED	
ST ALPHONSUS REGIONAL MEDICAL CENTEI  1055 NORTH CURTIS ROAD BOISE, ID 83706  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  BB173  Continued From page 40  blanches at 3 seconds, pink and skin is broken at surface. Left buttock is pink and blanches well, skin infact, Xenoderm applied to both sites." At 8:00 AM the notes stated "Small open area on right coccyx. Redness over several inch area, right and left coccyx. Xenaderm being used."  - 8/23/07: Patient #24 was discharged from the hospital.  Patient #24's record did not contain documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. He		130007					11/2	20/2007
STALPHONSUS REGIONAL MEDICAL CENTER   BOISE, ID 83706	NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  BB173  Continued From page 40  blanches at 3 seconds, pink and skin is broken at surface. Left buttock is pink and blanches well, skin intact, Xenoderm applied to both sites." At 8:00 AM the notes stated "Small open area on right coccyx. Redness over several inch area, right and left coccyx. Xenaderm being used."  - 8/23/07: Patient #24 was discharged from the hospital.  Patient #24's record did not contain documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. He	ST ALP	HONSUS REGIONAL M	MEDICAL CENTE			ROAD		
blanches at 3 seconds, pink and skin is broken at surface. Left buttock is pink and blanches well, skin intact, Xenoderm applied to both sites." At 8:00 AM the notes stated "Small open area on right coccyx. Redness over several inch area, right and left coccyx. Xenaderm being used."  - 8/23/07: Patient #24 was discharged from the hospital.  Patient #24's record did not contain documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. He	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
reducing support surface as per policy until 8/21/07. On 11/9/07 at 9:10 AM, a CWOCN nurse confirmed the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer until 8/21/07, the day of the prevalence study. The nurse also confirmed the above documentation.  The Supervising RN failed to ensure Patient #24 received appropriate preventative care which was consistent with the Braden scale policy interventions.  * Patient #23 was admitted to the hospital on 8/16/07 and was discharged on 8/23/07. The patient was an 87 year old female who had a ground level fall and had a history of degenerative joint disease of the spine and hip. She also had a history of diabetes with chronic renal insufficiency. Her medical record documented she did not receive wound care in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy as	BB173	blanches at 3 seconsurface. Left buttonskin intact, Xenode 8:00 AM the notes right coccyx. Rednight and left coccy. Rednight and left coccyx. Rednight and left coccy. Rednight and left coccyx. Rednight and left	ands, pink and skin is ck is pink and blanch is stated "Small open a ness over several incix. Xenaderm being is 24 was discharged find did not contain the was provided with the was provided with the was provided with an appropriate prurface as per policy to 7 at 9:10 AM, a CWO e CWOCN department in the provided with an appropriate prurface as per policy to 7 at 9:10 AM, a CWO e CWOCN department in the provided with the nurse also contation.  Note that the provided with the preventative care with the preventative care with the provided and shistory of disease of the spine at the provided with the provided in the provided with the provided in the provided with the provided in the prov	nes well, ites." At area on h area, used." area on the scale 4. He ressure until OCN ent was the e day of confirmed attent #24 which was tal on . The had a and hip. chronic care in essure LTURE,	BB173			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN B. WING		(X3) DATE S COMPLE	
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BB173	Continued From pa	ige 41		BB173			
	- 8/16/07: At 1:00 PM EMTEK notes documented "Skin Breakdownsacrumsmall open area 1inX1/4 in w/surrounding redness. Cream applied."						The state of the s
	- 8/17/07: At 8:00 PM EMTEK notes documented barrier cream was applied.						
	- 8/18/07: At 8:00 PM EMTEK notes documented "Skin BreakdownsacrumRed with no drainage, barrier applied no Dressing."						
	- 8/19/07: At 8:00 AM EMTEK notes documented no breakdown noted. However, EMTEK notes at 8:00 PM documented "Skin BreakdownsacrumHealing without s/s [signs/symptoms] of infection."						
	- 8/20/07: At 8:00 AM EMTEK notes documented "Skin breakdownsacrum reddened, skin intact."			!			THE STATE OF THE S
	- 8/21/07: At 8:00 AM EMTEK notes documented "skin breakdownsacrumblanchable half dollar sized red area on left upper buttock." Additionally, the hospital's 8/21/07 "Prevalence Report" documented Patient #23 was at risk and had developed a hospital and a unit acquired pressure ulcer. The report documented she had developed a stage 1 and a stage 2 pressure ulcer and that there was "No Evidence" of "Pressure Ulcer Prevention" measures being used. However, summary documented a stage 1 hospital acquired pressure ulcer on her spine. However, the summary did not include documentation of the pressure area on her sacral area.						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE S COMPLE	
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BB173	- 8/22/07: At 8:00 F "Skin breakdown area, open to air, n - 8/23/07: Patient # Patient #23's record documentation relat Additionally, there were that nursing staff for caring for Patient # (cleansing with nor applying barrier crewith a foam or non-accordance with the ULCER-ASSESSM IRRIGATION AND Further, there was the CWOCN Nurse open wound.  On 11/9/07 at 9:30 confirmed the CWOCN consulted by nursing pressure ulcer.  The Supervising RI received appropriate with the "WOUND at ULCER-ASSESSM IRRIGATION AND * Patient #57 was a 9/16/07 and was dispatient was a 67 ye history of amyloidos disease managed wedical record did	PM EMTEK notes do sacrumstage 2 coor so drainage."  23 was discharged.  23 was discharged.  24 did not contain contated to her skin integrated to her skin integrated saline, using skin stage 2 pressur mal saline, using skin earn twice daily, and earn twice daily, and earn twice daily, and PREMENT and CARE; CU DEBRIDEMENT" por no documented evide was consulted regard.  A.M., a CWOCN number of the care which was consulted regard.  A.M., a CWOCN number of the care which was consulted regard.  A.M., a CWOCN number of the care which was consulted regard.  A.M., a CWOCN number of the care which was consulted to ensure Patte care which was consulted to the pattern of the care which was consulted to the hospital sicharged on 10/2/07 around female who has sis and end stage regard with peritoneal dialys not include documents.	nsistent rity. evidence policy in e ulcer n prep, covering in ESSURE JLTURE, blicy. lence that liding the rse s not sient's latient #23 bnsistent lLTURE, blicy. tal on The ad a nal is. Her intation	BB173			
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BB173	[left] heelsArea re [signs/symptoms] I At 8:00 PM, the "Inher nursing assess Breakdownbuttowith little to no drait treated with topical also stated"Redd [left] heelsSkin re replaced"  - 9/28/07: Her treat Braden score as 1 section of her nurs AM, "Skin Breakdarea with yellow ce cleansed and ointrassessment also seright] and L [left] heelsbuttod drainage from ope - 9/30/07: Her treat Braden score as 1 "Integumentary/Sk assessment stated Breakdownbuttod drainage from ope - 9/30/07: Her treat Braden score as 1 section of her nurs PM, "Skin Breakdreddened with yellocleaned and topical assessment also seright] and L [left] heed"  - 10/1/07: Her treat	eddened, no s/s breakdown, heels ele ntegumentary/Skin" se sment stated"Skin cksSkin is red with inage. Wound cleane I cream" The asses dened SkinR [right] emains red, ted hose timent flow sheet liste 8. The "Integumenta sing assessment state downbuttocksred enter noted to coccyx, ment applied" The stated "Reddened S neelsreddened" timent flow sheet liste 7 and 14. The sin" section of her nurs d at 8:00 PM, "Skin cksskin is red with I n area." timent flow sheet liste 7. The "Integumenta sing assessment state downbuttocksAre by noted to center, an al cream applied" T stated "Reddened Sk neelsreddened, elev timent flow sheet liste with the state the state of the state the state	d her ry/Skin" ed at 8:00 dened area kinR d her ry/Skin" ed at 8:00 dened area kinR	BB173			
		<ol><li>The "Integumenta ing assessment state</li></ol>					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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BB173	Continued From page 46			BB173			
	PM, "Skin Breakd Dressing clean, dry also stated "Redd [left] heelsredden note at 1:57 PM state breakdown of the bred open areas at to the area - covere on the skin"  - 10/2/07: Patient #thospital.  Despite documentate to be ordered on 9/2 seen by the CWOC the patient's EMTEI had followed hospit pressure ulcer with around wound edge.	downbuttocks[cher, intact" The assessioned SkinR [right] ed" Additionally, a lated "Patient with operattocks - yellow sloug pplied criticaid with a led with saran wrap to 57 was discharged from that a wound co 22/07, Patient #57 with a late of the late of the late of the late of	essment and L CWOCN en skin gh and ntifungal keep it from the  insult was as not ne interim, nursing sed the skin prep e wound				
	received appropriat with the "WOUND a ULCER-ASSESSM IRRIGATION AND  * Patient #59 was a 10/29/07 and dischapatient's History and PM on 10/29/07, standisease, congestive obstructive pulmona dementia, status poof TIA's. She prese admitted due to accurate the control of the cont	N failed to ensure Partie care which was column PRESSURE ENT and CARE; CUI DEBRIDEMENT" polarited to the hospital arged on 11/5/07. The Physical, dictated a lated the patient was a story of coronary arter the heart failure, chronically disease, moderate story are pacemaker, and a lated to the ED and wate shortness of bread the stated Patient #59 at stated Patient #59 at stated Patient #59 at a care which was a stated Patient #59 at a care which was a stated Patient #59 at a care which was a car	nsistent  LTURE, licy.  al on he at 4:35 a 94 year ery c te a history was th. The				

STATE FORM JX1N11 If continuation sheet 47 of 52

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN			
	130007			B. WING _		11/2	20/2007
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BB173	Continued From pa	ge 47	,	BB173			
	September for suppalso noted the patie due to a previous was Treatment Flows	to the hospital in Aug posed CHF exacerba ent's right leg was ba round on the right shi heet in the patient's r den scale score of 13	itions. It ndaged in. ecord				
	The patient's EMTEK under the ACTIVITY Position section did not contain documented evidence the patient had been repositioned every 2 hours or was provided supplemental turning with small shifts in position during the following dates and times:						
	remained supine from the patient's record Breakdown),, R Low (clean, dry, intact). RN documentation patient's record at 8	rom 5:45 PM to 10:0 om being repositione to 6:00 AM. At 6:00 F Assessments/Notes "Integrity Impairmen ver Calf): Dressing C Not assessed at this in the same section 6:00 PM stated "Integreakdown),, R Lower intact."	d at 10:00 PM an RN section of t (Skin DI stime." of the				
	8:00 AM RN nursing was removed from right calf to find grefurther information adocumented by the patient's Treatment Braden Scale score note, at 2:00 PM staffrom previous hosp wound on back of lewound healing and	rom 6:00 AM to 2:00 g note stated the bar the wound on the paren ointment in the woregarding the wound RN. Also at 8:00 AM Flowsheet document of 16. A CWOCN rated "patient known to talization - has an opert calf - spoke with contract and the paragraph of the pa	ndage tient's ound. No was If the nted a nursing to service ben tenter for state that				

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	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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boot - when dressing removed pan place on a [sic] exudry - spoke with center patient was admitted from) swound VAC was stopped because orders were obtain [sic], they believ resident physician - will place woun patient at this time with with [sic] guand allevyn foam- wrap with kerlix."  - 10/30/07; as sitting in a chair 4:00 PM. Hygiene activities and a linened noted on the patient's Treatment FI 4:00 PM. An RN nursing note doct 8:00 PM that the dressing on Patie wound was clean, dry, and intact.  - 10/31/07: supine from 11:00 AM to which time a PT assessment was conthe right from 8:00 PM to 12:00 On 10/31/07 at 12:00 AM an RN nustated Patient #59's gown and bedefrom a leak in her foley catheter. A LPN nursing note indicated the drepatient's calf wound was clean, dry Braden Scale score of 16 was also in the Treatment Flowsheet at the skin integrity at 5:30 PM. The asse included a new pressure sore "Ni purple, and reddened area to butto break down. Pt. turn [sic] off of but advise [sic] to stay off of her buttoc intact and no s/s of infection noted. turned every 2 hours." The skin brother at 8:00 PM.  The only documentation of the statishape) of Patient #59's calf wound	nurse at (care states that the of pain and red, from their d gel on raze dressing -  PM to 8:00 change were owsheet at amented at a temperated and AM 11/1/07. It is in the same time. An and intact. A documented same time.	BB173				

Bureau of Facility Standards STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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ST AL PHONENS DECIONAL MEDICAL CENTER 1055 NOR		RTH CURTIS ROAD					
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BB173	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		BB173				
	patient on 1st step mattress overlay w 11/2/07. PT notes 11/2/07 stated Pati fatigue. At 8:00 PM the dressing on the and intact and that	mattress on area." as initiated at 10:00 at 11:23 AM and 4:0 ent #59 refused ther M, an RN nursing note calf wound was cles	The AM 00 PM on apy due to te stated an, dry, uttocks				

Bureau of Facility Standards

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		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED - 11/20/2007		
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BB173	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			BB173				
	Patient #59 was di	scharged to a nursing	g facility at					

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BB173 Continued From page 51 BB173		
On 11/9/07 at 10:40 AM, a CWOCN nurse confirmed the above documentation and stated it was the hospital's best practice to turn patients at least every 2 hours. The hospital failed to ensure Patient #59 was provided with services necessary to prevent skin breakdown and that the status of her wounds was consistently documented to monitor healing or lack thereof.  Note: B173 continued at B9999.		

Bureau of Facility Standards

JX1N11



# IDAHO DEPARTMENT

# HEALTH & WELFARE

C. L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

January 10, 2008

Sandra Bruce St Alphonsus Regional Medical Center 1055 North Curtis Road Boise, Idaho 83706

Provider #130007

Dear Ms. Bruce:

On November 20, 2007, a Complaint Investigation was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

## Complaint #ID00003245

Allegation #1: A patient's left femur was fractured on 10/5 or 10/7/07 when staff turned the patient.

Findings: An unannounced visit was made to the hospital on 11/5/07. Ten clinical records were reviewed of patients hospitalized during the time of the alleged incident. Additionally, staff were interviewed.

One patient's medical record documented she was admitted to the hospital on 10/3/07 for pneumonia and discharged on 10/15/07. The record contained a report from the ambulance that transported the patient from her residence to the hospital. The report, dated 10/3/07, documented the patient reported pain in her "left ankle and left hip from an injury that occurred approx 1 week ago when a home health aide accidentally pulled her leg in the wrong direction." A hospital admission history and physical, dated 10/3/07, documented the patient complained of tenderness in her left ankle.

Physician's progress notes documented the following:

10/6/07 at 8:30 AM: "TTP (tender to palpation) in L (left) ankle, x-ray negative ankle fx (fracture), possible stress fracture 3rd and 4th metatarsal (part of the foot)." 10/7/07 at 9:45 AM: "c/o (complained of) L knee pain" and "L knee tender to movement...pain with flexion..."

10/11/07 at 8:15 AM: patient complained of increased pain to "legs, hips." 10/13/07 at 11:00 AM: "still has knee pain"

Physician's progress notes did not contain documentation of a fracture during her stay.

Nursing notes documented the following:

10/7/07 at 8:00 AM: the patient's pain is "primarily to her shoulders and to her left foot and knee."

10/7/07 at 10:00 PM: "calls out in pain when any of her extremities are moved... no pain at rest."

10/8/07 at 10:00 PM: "complains of pain in her lower legs."

10/10/07 at 10:00 PM: complained of "aching pain to left knee."

10/11/07 at 10:00 PM: did not allow RN to assess left heel as patient "states it hurts from a fracture she sustained."

10/12/07 at 8:00 AM: complained of left hip and knee pain. "Pain rated 2/10, aching."

10/14/07 at 10:00 PM: patient complaining of aching pain "7/10" to left knee

Nursing notes did not contain documentation the patient complained that her leg had been fractured or injured while she was hospitalized.

Physical Therapy notes included the following documentation:

10/8/07 at 1:30 PM - complained right "shoulder dislocated" 10/9/07 at 1:30 PM - "states left leg is broken and to leave it be"

Physical Therapy notes did not contain documentation that the patient complained that her leg had been fractured or injured while she was hospitalized.

On 11/7/07 at 2:40 PM, an RN who knew the patient personally and worked with her on discharge planning was interviewed. She stated the patient complained of pain in numerous areas but did not state her leg had been fractured. She stated the patient frequently refused to be moved and didn't want to be touched.

On 11/7/07 at 3:00 PM, an RN who was a charge nurse was interviewed. She stated she knew the patient personally and also provided care for her was interviewed.

She stated they used a "lift" to raise the patient to clean her and change the bedding. She stated the patient did not complain that her leg had been fractured. Additionally, she stated the patient's pain level remained constant throughout her hospitalization.

On 11/8/07 at 8:00 AM, an RN who cared for the patient while she was on the telemetry unit was interviewed. He stated the patient did not complain that her leg had been fractured when turned at the hospital. He stated they used a "lift" to elevate the patient to clean her and change the bedding. He said she would complain of pain with any movement and there was no change in her pain level while she was on the telemetry unit.

On 11/8/07 at 8:10 AM, a Physical Therapist who provided care to the patient while she was hospitalized was interviewed. She confirmed she documented that the patient stated her leg was broken and to leave it alone. She said the way the patient told her about the leg led her to believe it had happened in the past. She stated the patient did not tell her that her leg had been fractured or injured while she was in the hospital.

Unsubstantiated. Although the patient's leg may have been fractured when she was hospitalized, there was no evidence to validate the complaint. Additionally, the patient had complained of an injured left leg prior to her admission to the hospital.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The call light, which was activated by a blow straw, was placed out of the reach of a bed bound patient.

Findings: Ten clinical records were reviewed. All records contained "Treatment Flow" sheets that documented the type and accessibility of call lights provided to patients during hospitalization.

One patient's record documented she was provided a standard call light from 10/3 to 10/7/07 at 8:00 PM when she was given a call light that was activated with a blow straw. She continued to use the blow straw until her discharge on 10/15/07. "Treatment Flow" sheets documented the call light was accessible by the patient during her hospitalization.

On 11/5 and 11/6/07 a tour of the hospital was conducted and patient's were interviewed. Patient's interviewed had no complaints about call lights not being place within their reach. During the tour it was noted that all patient rooms had call lights accessible to patients either on the bed rail or a hand held model attached to the wall.

On 11/7/07 at 3:00 PM, an RN who was a charge nurse and had provided care to the

She stated if the call light was out of reach for the patient she was unaware of it. She stated the patient did not complain to her that she had been unable to alert staff.

On 11/8/07 at 8:00 AM, an RN who had provided care to the patient stated he was unaware of anytime the patient's call light was not accessible. He said the patient did not complain to him that she had been unable to access her call light.

Unsubstantiated. Although the allegation may have occurred, it could not be validated during the survey.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A patient who requested not to receive morphine was given the medication on two occasions.

Findings: One patient's record documented a physician's order for PRN (as needed) morphine. The patient's record documented nursing staff offered her pain medication, which included morphine, when she complained of pain. The record also documented she was offered pain medication prior to staff providing care which might cause her discomfort. Nursing notes documented that there were times the patient was offered morphine for pain and she refused. Additionally, nursing notes also documented there were times the patient took morphine for pain. Review of the patient's MAR (medication administration record) did not document a time when the patient was given pain medication that she had refused.

Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation. There was no evidence that the patient was unable to refuse medications that were offered.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A patient who thought their femur was fractured during their hospitalization requested an x-ray from physicians and nurses but they refused.

Findings: One patient's medical record documented she was admitted to the hospital on 10/3/07 for pneumonia and was discharged on 10/15/07. Physician's progress notes, dated 10/3 through 10/15/07 did not contain documentation that the patient requested an x-ray of her left leg. Additionally, nursing notes, dated 10/3 through 10/15/07, did not contain documentation that the patient wanted an x-ray of her left leg.

On 11/7/07 at 2:40 PM, an RN who knew the patient personally and worked with her on discharge planning was interviewed.

She stated the patient did not tell her that she thought her leg was fractured or complained that she had been injured while hospitalized. She said that patient did not tell her that she wanted an x-ray of her leg.

On 11/7/07 at 3:00 PM, an RN who was a charge nurse, knew the patient personally and provided care for her was interviewed. She stated the patient did not complain that her leg had been fractured. Additionally, she stated the patient did not request an x-ray of her leg that she was aware of.

On 11/8/07 at 8:00 AM, an RN who cared for the patient while she was on the telemetry unit was interviewed. He stated the patient did not complain that her leg had been broken when turned at the hospital. Additionally, he stated the patient did not request an x-ray of her leg that he was aware of.

Unsubstantiated. Although the patient may have requested an x-ray of her left leg there was no documentation contained in the record, or confirmed by interview that substantiated the allegation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

RAE JEAN MCPHILLIPS

Health Facility Surveyor

Non-Long Term Care

SVI VIA CRESWELL

Co-Supervisor

Non-Long Term Care

RJM/mlw



HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

11.7137

January 30, 2008

Sandra Bruce St Alphonsus Regional Medical Center 1055 North Curtis Road Boise, Idaho 83706

Dear Ms. Bruce:

On November 20, 2007, a Complaint Investigation was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

### Complaint #ID00003216

Allegation: Patients were not repositioned at the hospital in an effort to prevent the pressure allegers and patients subsequently developed pressure ulcers.

Findings: An unannounced visit was made to the hospital on 11/5/07. 18 clinical records were reviewed of patients who had developed hospital acquired pressure ulcers during their stay at the hospital. The hospital policies and quality improvement program was also reviewed. Additionally, staff were interviewed.

One patient's record revealed the patient was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. The patient was a 66 year old male that was admitted to the hospital after being found unresponsive in his home. The patient's Braden scale on 8/13/07 was 9 (severe risk: supplement turning with small shifts in position, provide appropriate pressure reducing support surface, Certified Wound-Ostomy-Continence Nurse consult). The patient's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 9. Additionally, the "ACTIVITY Position" section of his EMTEK documented that he had not been repositioned every 2 hours or provided supplemental turning with small shifts in position.

Sandra Bruce, January 30, 2008 Page 2 of 2

It was further discovered that appropriate wound care had not occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24 - 48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Lastly, a CWOCN was not contacted until 8/21/07 despite his low Braden scores (prior to the 8/23/07 score of 18) and having an open wound since 8/18/07. His medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the CWOCN nurse consult on 8/21/07 at 11:30 AM.

After the investigation, it was determined the hospital failed to provide adequate care for 8 of 18 patients on an ongoing basis in accordance with accepted standards of nursing practices and hospital's policies. The hospital's nursing staff failed to follow the hospital's "BRADEN SCALE for Predicting Ulcer Risk" policy interventions, and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy and interventions. The cumulative effect of these negative facility practices resulted in harm to patients, and the potential for serious harm or death to occur.

Deficiencies were cited at 42 CFR 482.23 Condition of Participation: Nursing services for the failure of the hospital to ensure that nursing staff had adequately cared for patients on an ongoing basis in accordance with accepted standards of nursing practices and hospital's policies. The hospital provided a plan of correction. A follow up survey was completed and the hospital was found in compliance with all Conditions of Participation.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON

Health Facility Surveyor

Non-Long Term Care

SVI VIA CRESWELL

Co-Supervisor

Non-Long Term Care



HEALTH & WELFARE

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Sandra Bruce, January 30, 2008 Page 2 of 2

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If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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